Intake Form

Name: ____ Date: _________________

Address: ____

Zip: ________ Email: ____

DOB: ___________________ Phone number: ___________________________________

How did you hear about Concierge Massage: ____________________________________

Cause of Injury, pain or area of concentration: __________________________________
When? ___________
Are you Pregnant: Y or N If so how many months? ___________ Are you under doctors Care? Y or N Has the doctor released you to receive massages? Y or N

AMOUNT OF PAIN: On a scale of "1" to "10". Please circle how you would rate the pain

1---2---3---4---5---6---7---8---9---10

Do you CURRENTLY have a history of the following:

__accident	**__sprains**	**__fibromayalgia**	**__neck pain**
__seizures	**__breast Aug.**	**__whip lash**	**__abdominal pain**
__diabetes	**__headaches**	**__nervous tension**	**__varicose veins**
__disk problems	**__arthritis, bursitis**	**__high blood pressure**	**__mid back pain**
__gout	**__stroke**	**__low back pain**	**__allergies to oil/perfume**
__heart attack	**__joint pain/ache**	**__wear contact lens**	**__cancer**
__decreased range of motion		**__colitis**	**__broken bones**
__surgery/surgeries	**__infections**	**__cold or flu/with fever**	

Type of Surgeries:

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I have completed this information form to the best of my knowledge. I understand the massage services are designed to be an health aid and are in No way to take the place of a doctor's care, when it is indicated. Information exchanged during the massage session is education in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. Our time together is precious and we request sufficient time to replace your appointment (48 hours) I agree to pay half of the appointment fee if I don't cancel within 48-25 hours and pay full fee if cancelled with (24 hours) of scheduled appointment.

Date: _________________ Signature: ____

If a minor: (Parent's signature) Parent must be in the session room during the massage:

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