THE FAMILY WELLNESS CENTER

1000 Briarsdale Road Harrisburg, PA 17109 (717) 558-8500 Fax (717) 558-8567

MASSAGE AND DAY SPA INTAKE FORM

DATE: _____

NAME: _____ DOB: ____/____/_____

ADDRESS: _____ PHONE DAY: _____

CITY/STATE/ZIP: _____ PHONE EVE: _____

EMAIL: _____ REFERRED BY: _____

OCCUPATION/EMPLOYER: _____

PRIMARY HEALTH CARE PROVIDER: _____ PHONE: _____

PERMISSION TO CONSULT WITH PRIMARY PROVIDER? _____ YES _____ NO (IF YES, INITIAL)

EMERGENCY CONTACT: _____ PHONE: _____

MASSAGE HISTORY/ TREATMENT INFORMATION

HAVE YOU EVER RECEIVED A PROFESSIONAL MASSAGE? _____ YES _____ NO

IF YES, HOW OFTEN? _____ DATE OF LAST MASSAGE _____

ARE YOU SEEKING A THERAPEUTIC MASSAGE, DEEP RELAXATION, ENERGY WORK (such as Reiki), OR A COMBINATION?

_____

ARE THERE ANY AREAS OF YOUR BODY THAT YOU PREFER **NOT** TO BE MASSAGED? _____

ARE YOU CURRENTLY SEEING A MEDICAL PRACTITIONER? _____ YES _____ NO

IF YES, PLEASE EXPLAIN: _____

_____

ARE YOU CURRENTLY SEEING A PSYCHOTHERAPIST, CHIROPRACTOR, OR OTHER SPECIALIST? _____ YES _____ NO

IF YES, PLEASE EXPLAIN: _____

_____

LIST CURRENT MEDICATIONS/SUPPLEMENTS—INCLUDE ASPRIN, IBUPROFEN, VITAMINS, ETC.

_____

PREVIOUS SURGERIES OR ACCIDENTS (INCLUDE YEAR) _____

_____

MASSAGE CLIENT HEALTH HISTORY

Please check all that apply and provide additional information as needed.

MUSCULO-SKELETAL
___ BONE OR JOINT DISEASE _____
___ TENDONITIS _____
___ BURSITIS _____
___ BROKEN/FRACTURED BONES _____
___ ARTHRITIS _____
___ SPRAINS/STRAINS _____
___ NECK, SHOULDER/HEAD INJURIES
___ JOINT REPLACEMENT _____
___ METAL IMPLANT _____
___ SPASMS/ CRAMPS _____
___ JAW PAIN/ TMJ
___ FIBROMYALGIA
___ OSTEOPOROSIS
___ OTHER _____

CIRCULATORY
___ OPEN HEART SURGERY
___ HEART CONDITION _____
___ BLOOD CLOTS _____
___ PACE MAKER
___ HIGH BLOOD PRESSURE
___ LOW BLOOD PRESSURE
___ LYMPHEDEMA
___ OTHER _____

RESPIRATORY
___ BREATHING DIFFICULTY
___ SINUS PROBLEMS
___ ALLERGIES _____
___ ASTHMA
___ EMPHYSEMA
___ VIRUS OR FLU-LIKE SYMPTOMS
___ OTHER _____

GENITAL-URINARY
___ PROSTATE _____
___ BLADDER _____
___ KIDNEY _____
___ OTHER _____

SKIN
___ ALLERGIES _____
___ RASHES _____
___ WARTS _____
___ ATHLETE'S FOOT _____
___ SENSITIVITY TO FRAGRANCES OR OILS
___ OTHER _____

DIGESTIVE
___ CONSTIPATION
___ GAS/ BLOATING
___ DIVERTICULITIS
___ IRRITABLE BOWEL SYNDROME
___ CROHN'S DISEASE
___ OTHER _____

NERVOUS SYSTEM
___ HERPES/SHINGLES _____
___ NUMBNESS/ TINGLING _____
___ CHRONIC PAIN _____
___ HEADACHES _____
___ FATIGUE _____
___ SLEEP DISORDERS _____
___ OTHER _____

REPRODUCTIVE
___ PREGNANT? _____ STAGE _____
___ PMS
___ OTHER _____

OTHER
___ CANCER/TUMORS _____
___ DIABETES
___ CONTACT LENSES
___ EATING DISORDERS _____
___ DEPRESSION
___ DRUG/ALCOHOL ADDICTION _____
___ EPILEPSY/SEIZURES
___ LUPUS
___ NICOTINE/CAFFEINE _____
___ OTHER

INFECTIOUS DISEASE
___ DISEASE NAME(S) _____

IT IS MY CHOICE TO RECEIVE MASSAGE THERAPY. I REALIZE THAT THE TREATMENT IS BEING GIVEN FOR THE WELL-BEING OF MY BODY AND MIND. THIS INCLUDES STRESS REDUCTION RELIEF FROM MUSCULAR TENSION, SPASM, OR PAIN, OR FOR INCREASING CIRCULATION OR ENERGY FLOW. I AGREE TO COMMUNICATE WITH MY PRACTITIONER ANY TIME I FEEL AS IF MY WELL-BEING IS BEING COMPROMISED. I UNDERSTAND THAT MASSAGE PRACTITIONERS DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDER, NOR DO THEY PRESCRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. I ACKNOWLEDGE THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION OR DIAGNOSIS, AND THAT IT IS RECOMMENDED THAT I SEE A PRIMARY HEALTH CARE PROVIDER FOR THAT SERVICE. I HAVE STATED ALL MEDICAL CONDITIONS THAT I AM AWARE OF AND WILL UPDATE THE MASSAGE PRACTITIONER OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE_____ DATE _____

MASSAGE CANCELLATION POLICY

As a courtesy to our massage therapists, please provide at least 24 hours notice if you need to reschedule or cancel your massage. If you fail to arrive for your scheduled appointment, you will be charged a fee equal to 50% the cost of the massage. We require your Credit Card information which will be kept on record in your file. We will only charge your card if you fail to follow The Family Wellness Center, Massage Cancellation Policy. Please notify us to a change in your scheduled appointment by calling (717) 558-8500 as soon as you are able. Thank you for your consideration.

I have read the Massage Cancellation Policy and understand that I will be charged 50% the cost of the massage if I do not give 24 hours notice for my scheduled appointment.

Signature: _____ Date: _____

Credit Card: _____

Expiration:____/____ CVV: _____