Confidential Massage Intake Form

_ _

Mr. Mrs. Ms Name　　Date of Birth　　Referred by

_ _

Address　　City, State Zip　　SS#

_ _

Employer　　Work Phone　　Home Phone　　Cell Phone

Is this your first massage? _ _ _ _ _ _ _ _ Reason for visit_ _

Please lit major illnesses, surgeries or hospitalizations during the past 5 years_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Please Circle any of the below that apply:

Contact lenses	Acute Inflammation	Fever
Localized infection	Pregnancy	Communicable Illness

Do you now have or have you had any of the following within the last 5 years (please Circle)

Heart problems	Thrombosis/embolism	AIDS/HIV+
Ovarian/menstrual Cancer	Constipation	TMJ
Arthritis/lumbago/gout	Skin problems	Diabetes
Bursitis/joint disorders	Ulcerated Colon	Sciatica
Kidney/bladder ailment	Phlebitis/varicose veins	Osteoporosis
Chronic illness/pain	neck/spinal injury	hayfever/allergies
migraines/headaches	respiratory/lung problems	
High/low blood pressure		

Are you currently under the care of a health care professional? _

_ _

Names of professional　　Title/Specialty　　Phone

Please list any medications taken at regular intervals: _

_ _

The above information is true and accurate to the best of my knowledge. In the state of Washington, I, Hinkle, LMP are licensed health care providers in the area of massage therapy. If this therapy has been prescribed as a result of you injuries, we will be happy to bill your insurance as a courtesy. If any treatment is denied or not paid in full by your insurance company, it is your financial responsibility to pay for treatment. I also agree to pay for any missed appointments for which 24 hour's notice was not given.

_ _

DATE　　SIGNATURE

*****Accident Only****** I herby grant Elizabeth Hinkle, LMP a lien against any and all awards or settlements I may receive because of the accident on _ _ _ _ _ _ _ _ _ _ _ _ _, in the full amount of any bills remaining unpaid at the time I become entitled to receive such proceeds.

Insured name _　　SS of Insured _

Insurance company _　　Group or policy No _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

DOB of insured _　　Employer of Insured _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _