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 provide less than 4 hours notice or fail to arrive for your scheduled appointment, you will be charged a fee equal to 50% the cost of the massage. 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 at least 4 hours notice prior to canceling my massage or fail to arrive for my scheduled appointment.

Signature: ____ Date: ___________