New Patient Intake

Welcome to my practice!

Please help me serve you better by taking a few minutes to provide the following information.

Name: _____

Cell #: _____ Home #: _____

Address: _____ City, State, Zip: _____

Email: _____ DOB: _____ Female: ____ Male: ____

Emergency Contact and #: _____

Occupation: _____ Employer: _____

Referred by: _____ Allergies: _____

What is the primary issue/problem/reason that brings you in today? _____

_____

_____

What are your goals/expectations for this therapy session? _____

_____

_____

Please list all previous surgeries/trauma/falls: _____

_____

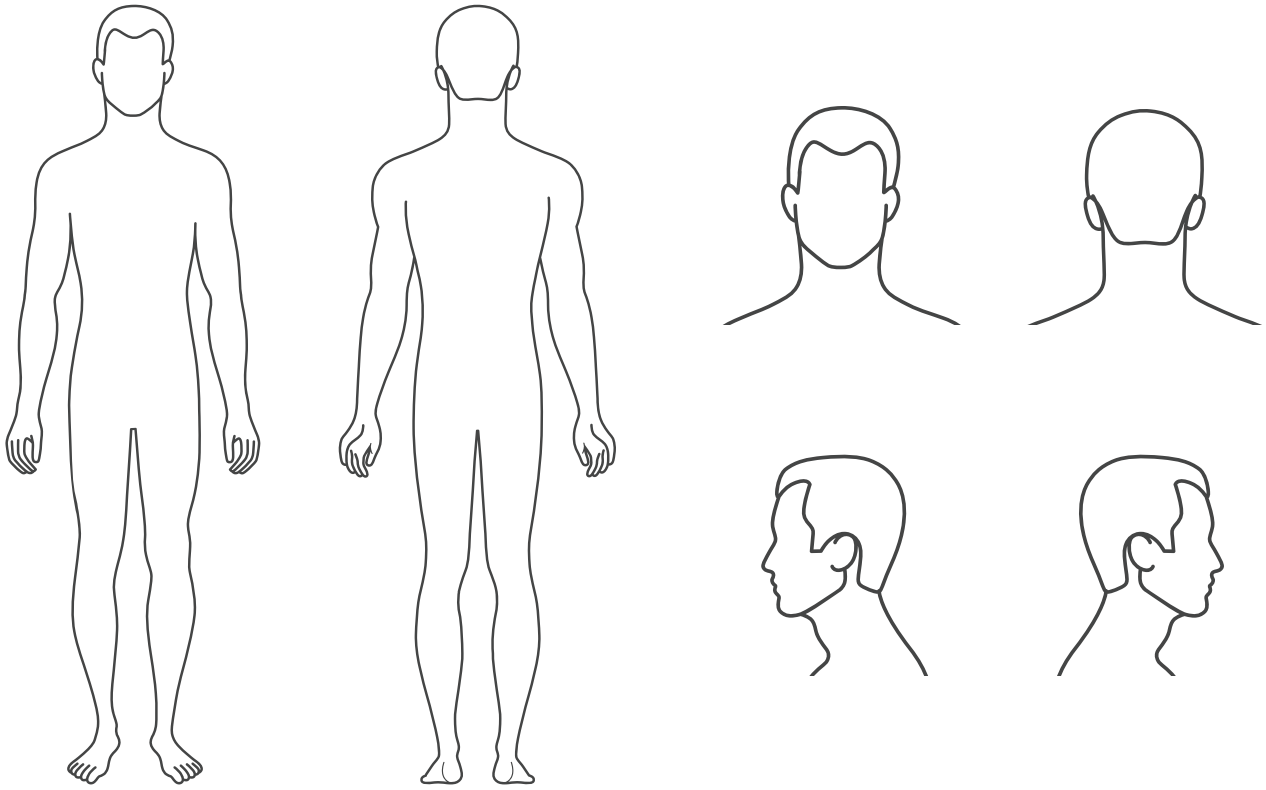
_____

Please list any Medication you are currently taking: _____

_____

_____

Please indicate any areas of concern:



Is there anything else you wish to mention? _____

_____

Do you have a history of the following? Check all that apply:

	Abdominal Pain		Carpal Tunnel		Liver Disorder
	Abdominal Surgery		Chronic Fatigue Syndrome		Low Back Pain
	Accident		Concussion		Mastectomy
	Acne		Diabetes		Neurological Disorder
	AIDS/HIV		Diarrhea		Numbness/Tingling
	Any Contagious Illness		Dizziness/Fainting		Paralysis
	Arthritis OA/RA		Decreased Range of Motion		Plates/Screws
	Asthma		Epilepsy/Seizures		Rash/Shingles
	Athlete's Foot		Emphysema		Scoliosis
	Anxiety		Fever		Sinusitis
	Back Pain		Fibromyalgia		Sleeping Issues
	Blood Clots		Heart Attack		Stents/Shunts
	Bleeding Disorders		Headaches/Migraines		Spinal Problems
	Broken Bones		Hernia		Stroke
	Breast Augmentation		High/Low Blood Pressure		Sciatica
	Bruises/Cuts/Wounds		Infection		Varicose Veins
	Cancer/Tumors		IBS		Other:
	Circulatory Problems		Joint Pain		
	Constipation		Kidney Disease		

Clients Waiver:

Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I may have. I understand that the massage therapist does not prescribe medical treatment of pharmaceuticals nor does the therapist perform any spinal adjustments. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions that there shall be no liability on the practitioner's part should I fail to do so. _____ *(Initial)*

Payment, Cancellation, and No Show Policy:

I understand that payment is due at time of service and that packages expire 3 months from the date of said purchase.

Payment, in the form of cash, check or credit card, is due at the time of each visit. Venmo: @lisaDcowan

Cancellations must be made 24 hours prior to your appointment time. If you do not show up for your appointment or cancel within 24 hours, you will be responsible for 50% of the session. Considerations will be made in cases of emergency and sickness. _____ *(Initial)*

Photography Waiver:

I allow Lisa D'Angelo to take and use my photo or my child's photo for social media usage. _____ *(Initial)*

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____