MEDICAL MASSAGE INTAKE FORM

Patient Name: ____ M____ F______

Address:____ State: __________ ZIP: _________

Date of Birth: ________________ Email Address: ____

Phone: Cell:_____________________ Home: _____________________ Work: ___________________

Occupation: ___________________________________ SSN: _________ - ________ - ______________

Insurance Company Name: ____

Address: ____

City:____ State: __________ ZIP: ________________

Adjuster:____ Phone: ______________________

Claim/Policy #:_______________________________________ Date of Incident: __________________

Name of Insured: _______________________________________ DOB: _______________________

Primary Care Physician: ____

Address: ____ City:_________________________

State: _________ ZIP:_____________ Phone: _______________________________

Attorney: ____

Address: ____ City: ___________________________

State: __________ ZIP: ____________ Phone: _______________________________

Emergency Contact: ____

Relationship: _______________________________________ Phone: _________________________

Is this case related to: Auto _____ Work _____ Other ______ Explain: _______________________________

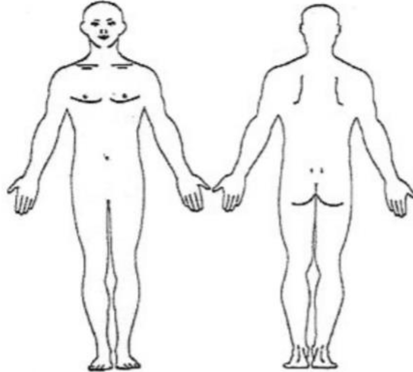
Has the insurance company been notified? Yes _____ No _____

Are you presently under a doctor's care? Yes _____ No _____

Have you ever been treated for the same condition? Yes_____ No _____

Were you admitted to the hospital? Yes _____ No ______ If Yes, for how long? ________________________

Please indicate with an X the places you are feeling discomfort:



What makes your condition worse? ____

____

What makes your condition better?____

____

Please list all medications you are taking: ____

____

Do you have a history of the following?

☐ Accident	☐ Varicose veins	☐ Decreased range of motion
☐ Neck Pain	☐ Surgery	☐ Broken bones
☐ Whiplash	☐ Arthritis	☐ Fibromyalgia
☐ Headaches	☐ Diabetes	☐ Cancer
☐ Disc problems	☐ Seizures	☐ Taking blood thinners
☐ Mid-back pain	☐ High blood pressure	☐ Nervous tension
☐ Low-back pain	☐ Heart attack	☐ Allergies to perfumes/oils

Have you ever received massage therapy? Yes _____ No _____