Alternative Pain Management

Intake Form

Name: _____ Cell #:_____

E-mail:_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Occupation:_____

Emergency Contact: _____ Phone: _____

Have you ever received massage before: ☐ Yes ☐ No

How often do you get a massage: ☐ weekly ☐ bi-weekly ☐ monthly ☐ yearly ☐ as needed

How did you hear about us? _____

What are your goals for this session: ☐ Reduce pain ☐ Relax ☐ Promote overall health & wellness

Other goals: _____

- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joint
- ☐ Asthma
- ☐ Athletes foot
- ☐ Blood clots
- ☐ Chronic Pain
- ☐ Constipation/Diarrhea
- ☐ Depression
- ☐ Diabetes
- ☐ Fatigue
- ☐ Fungus
- ☐ Headaches/ Migraines
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hernia
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Jaw pain
- ☐ Low blood pressure
- ☐ Muscle/ Bone injury
- ☐ Muscle/ Joint pain
- ☐ Numbness/ Tingling
- ☐ Pregnancy
- ☐ Rash
- ☐ Recent surgery
- ☐ Sinus problems
- ☐ Sleep difficulty
- ☐ Spinal Disorder
- ☐ Sprain/Strain
- ☐ Tension/Stress
- ☐ Vision problems
- ☐ Varicose veins

Other:_____

_____

Are you currently under a physicians care: ☐ Yes ☐ No

If yes, what for?:_____

Physicians Name:_____

List any surgeries within the past 5 years:_____

_____

_____

List all current medications: _____

_____

Circle areas you would like to addressed during your session and make any notes you may have

Notes

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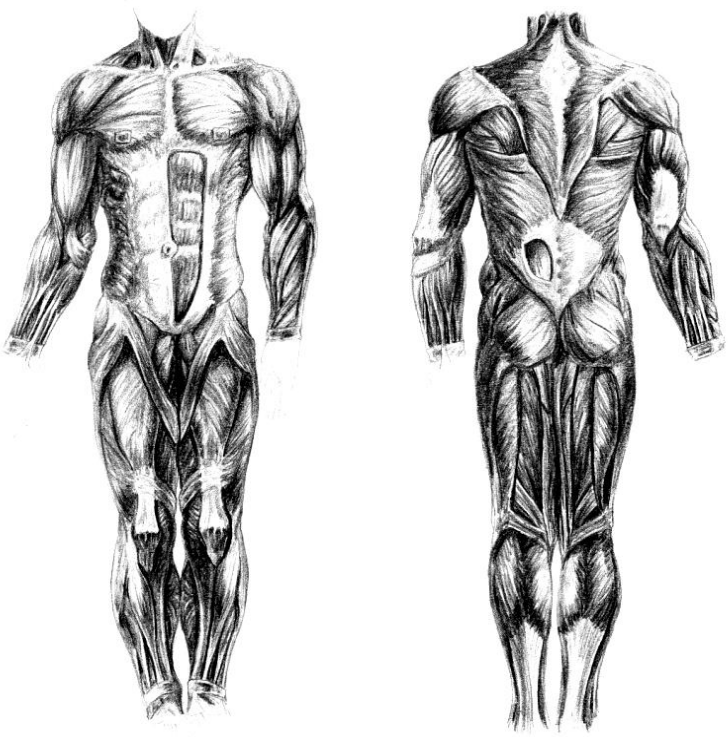

I understand that the services provided by Alternative Pain Management are to supplement, not replace medical care from my primary care physician. Massage Therapists are not qualified to perform spinal or skeletal adjustments and cannot diagnose any physical or mental illness. I also understand that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session, and I will be responsible for the payment of the scheduled appointment.

Cancelation/Rescheduling Policy

Twenty-four hour advance notice is required when canceling/rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. Anyone unable to give us 24 hours advance notice for cancelation/rescheduling will be charged the amount of the appointment scheduled.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show" and will be charged for the appointment scheduled and will be required to prepay for future appointments

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, you will be responsible for paying the full amount of the session scheduled. Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.

I hereby acknowledge my responsibility in communicating any physical concerns that might conflict with participation in such activity. I acknowledge that I assume all risk associated with participation in this activity, relinquishing all liability from Alternative Pain Management and its associates.

Signature: _____ Date: _____

Please turn your cell phone to “silent” during your session