INTAKE FORM

MASSAGE THERAPY

Date of First Session ______________________ Age ____________ DOB ____________

First Name ______________________ Last ______________________

Address ______________________ City ____________ State/Zip ____________

Email ______________________ Phone # ______________________

Occupation ______________________ Primary Physician ______________________

Have you seen one of the doctors at Natural Paths to Wellness? Yes No

If so, which one? ______________________ Date of last appointment ______________________

MEDICAL INFORMATION

Are you taking any medications? If so, please list:

1.

2.

3.

4.

5.

6.

Are you currently pregnant or nursing? Yes No

Do you have any health conditions your therapist should be aware of? If so, please list:

Do you suffer from chronic pain or have any orthopedic injuries? If so, please list:

Have you ever been diagnosed with cancer?

Do you have any allergies or sensitivities? If so, please list:

Has your lymphatic system been compromised, or have you had any lymph nodes removed? If so, how many?

MASSAGE INFORMATION

Have you had a professional massage before? Yes No

If so, when was your last session? ______________________________

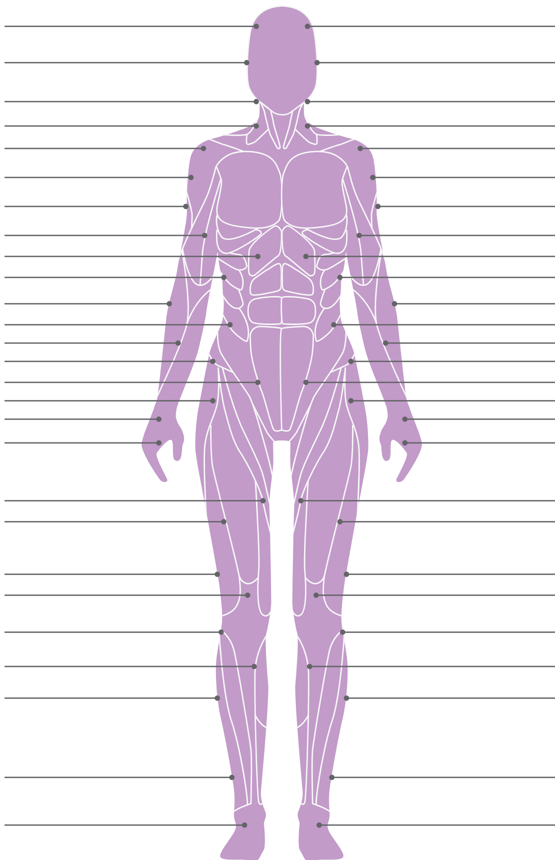
What type of massage treatment are you seeking? *Ex: relaxation, deep tissue, etc.*

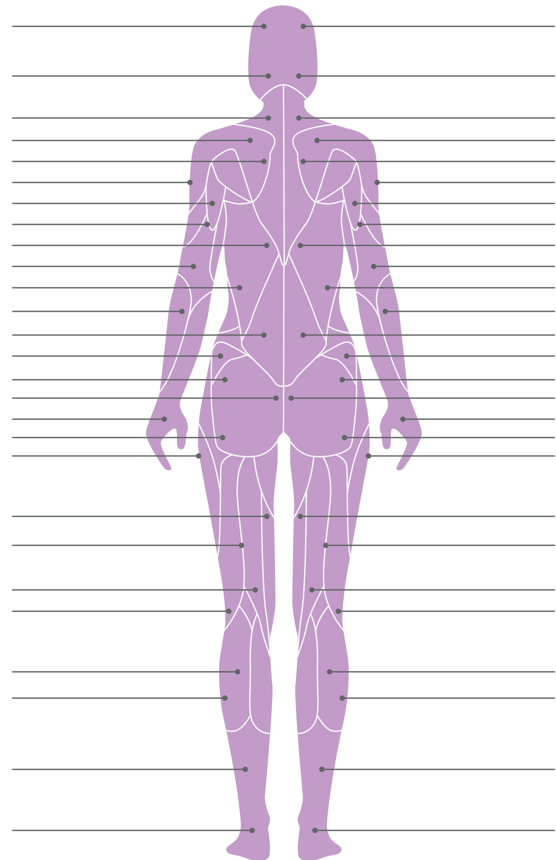
What pressure do you prefer? *Ex: light, medium, deep*

Are there any areas you **do not** want worked? *Ex: glutes, scalp, feet, etc.*

What are your goals for this treatment session?

Please identify any areas of discomfort or tension below. Check all that apply:





TREATMENT CONSENT

Please take a moment to read the following statements:

1. If I experience pain or discomfort during my session, I will immediately inform my therapist so they can adjust the pressure/strokes to my comfort level.

2. I understand that the services received are not a substitute for medical care. I understand that my therapist is not qualified to make a diagnosis, spinal adjustments, prescribe or treat any ailments.

3. I affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform my therapist of any changes in my health or medical conditions if they do occur.

INFORMATION & SUGGESTIONS

1. Prior to your massage, please remove glasses and all jewelry. We suggest you pull long hair back with a clip or hair band.

2. Please undress to your comfort level. Generally this is just undergarments, however, your therapist can meet you at your comfort level and adjust accordingly.

3. Feel free to ask questions before, during or after the session. You can always speak up and change things at any time.

CONSENT FOR TREATMENT

By signing this form, I am agreeing that I have read the above statements and information provided. I have provided true and accurate information for my therapist in regards to my personal and health information.

Signature ______________________________ Date ______________

FINANCIAL CONSENT

At Natural Paths to Wellness, we understand that unanticipated events occur in everyone's life. In our commitment to provide a quality experience to all of our clients and out of consideration for our Massage Therapist's time, we have adopted the following policies:

1. A credit card will be required for all new patient appointments to guarantee your appointment and reserve that time for you. Your card will not be charged unless you fail to provide 24 hours notice of cancellation, however, you may use it to pay for services at the completion of your appointment.

2. 50% of the amount of the services scheduled will be charged in full for clients who "no-show" or fail to cancel their reservation within a 24-hour time period. The determined amount will be charged to the credit card on file.

3. Financial responsibility for services you receive at the office is yours alone and is **due at the time of service**. Cash, check, debit cards, and all major credit cards (except American Express) are accepted as forms of payment.

4. Please arrive for your appointment(s) on or before your scheduled starting time. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

CONSENT OF FINANCIAL RESPONSIBILITY

I have read the above statement and understand that I am financially responsible to Natural Paths to Wellness for all care and services provided to me and/or my dependents.

Signature ______________________________ Date ______________

Submit this form to Admin@NaturalPathsToWellness.com or fax to 717.430.0016

1524 Cedar Cliff Drive, Camp Hill PA, 17011 / 717.494.4500 / NaturalPathsToWellness.com