CAM Center of Hagerstown
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

MASSAGE INTAKE FORM

DATE: _____

NAME: _____
Last First Middle

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

EMAIL: _____

PREFERRED CONTACT PHONE #: _____ SECONDARY PHONE #: _____

DATE OF BIRTH: _____ AGE: _____ GENDER (Please circle): M / F

MARITAL STATUS: _____ # OF CHILDREN: _____ OCCUPATION: _____

IN CASE OF EMERGENCY CONTACT NAME: _____PHONE: _____

REASON(S) FOR TODAY'S VISIT:_____

_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN:

PAIN/TENDERNESS □ YES □ NO _____ STRESS □ YES □ NO _____

NUMBNESS/TINGLING □ YES □ NO _____ STIFFNESS □ YES □ NO _____

ALLERGIES □ YES □ NO ~ (medication, seasonal, topical, etc.) _____

PREGNANCY □ YES □ NO ~ If yes, how far along? _____ SWELLING □ YES □ NO _____

OTHER: _____

LIST ALL ILLNESSES, INJURIES AND HEALTH CONCERNS YOU HAVE NOW OR HAVE HAD IN THE PAST 3 YEARS. (Examples – arthritis, diabetes, high blood pressure, pregnancy, car accident, etc.) WHAT & WHEN? _____

_____

LIST ANY PRIOR SURGERIES AND YEAR:_____

_____

LIST MEDICATIONS AND SUPPLEMENTS YOU TAKE: _____

_____

HAVE YOU HAD MASSAGE BEFORE? □ YES □ NO WHAT PRESSURE DO YOU PREFER? □ LIGHT □ MODERATE □ DEEP

I understand that Kimberly Simpson, LMT and CAM Center of Hagerstown operate separately within the same office. I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I understand that I am responsible for payment if third party payment is not made. I agree to give 24-hour notice of cancellation of appointment. If less than 24-hour notice is given, I agree that the therapist may charge for the appointment. Cases of emergency are considered exceptions.

SIGNATURE: _____ DATE: _____