GREENWAVE
FAMILY WELLNESS CENTER

MASSAGE INTAKE

NAME _____ Home #_____ Work #_____ Cell #_____
ADDRESS _____ CITY _____ STATE_____ ZIP _____
DATE OF BIRTH _____ AGE _____ M_____ F_____ MARITAL STATUS_____
OCCUPATION _____ REFERRED BY_____
DO YOU HOPE TO USE INSURANCE YES NO DO YOU HAVE A PRESCRIPTION YES NO

HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES NO
TYPE OF MASSAGE EXPERIENCED:
DEEP TISSUE SWEDISH OTHER: _____
ARE YOU TAKING MEDICATION? _____ DESCRIBE _____

DO YOU HAVE A HISTORY OF THE FOLLOWING?

____ ACCIDENT
____ NECK PAIN
____ WHIPLASH
____ HEADACHES
____ DISK PROBLEMS
____ MID BACK PAIN
____ LOW BACK PAIN
____ JOINT ACHE
____ DECREASED RANGE OF MOTION
____ BROKEN BONES
____ SPRAINS
____ SEIZURES
____ ABDOMINAL PAIN
____ NERVOUS TENSION
____ ARTHRITIS, BURSITIS, GOUT
____ ALLERGIES DUE TO OILS OR PERFUMES
____ WEAR CONTACTS OR OTHER PROSTHESIS
_____ SURGERY
____ FIBROMYALGIA
____ BREAST AUGMENTATION
____ DIABETES
____ VARICOSE VEINS
____ HIGH BLOOD PRESSURE
____ STROKE
____ HEART ATTACK
____ CANCER
____ COLITIS
____ HIV

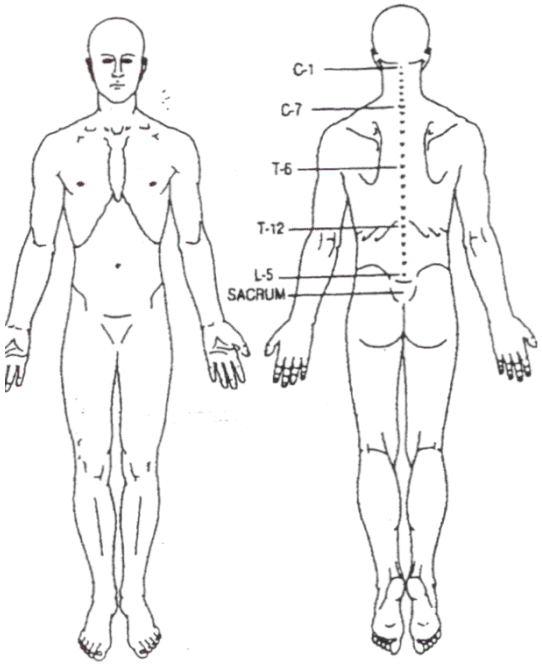
PLEASE INDICATE IF YOUR CONSUMPTION IS:

	NONE	LIGHT	MODERATE	HEAVY
SALT	____	____	____	____
SUGAR	____	____	____	____
CAFFEINE	____	____	____	____
TOBACCO	____	____	____	____
ALCOHOL	____	____	____	____
EXERCISE	____	____	____	____
WATER	____	____	____	____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

SUNBURN ____
INFLAMMATION ____
SEVERE PAIN ____
HEADACHE ____
OPEN CUTS, BRUISES, BURNS ____
IRRITATED SKIN RASH ____
POISON IVY ____
COLD/FLU ____

PLEASE INDICATE WITH AN (X) THE PLACES YOU ARE FEELING DISCOMFORT:



_____
_____
_____
_____
_____
_____

PLEAE READ THE FOLLOWING AND SIGN BELOW:

I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
I am responsible for paying for any appointment cancellation of less than 24 hours.

SIGNATURE: _____ DATE: _____