OSR Massage Intake Form

Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **DOB:** _____

Email: _____ **Primary Physician:** _____

Occupation: _____ **Employer:** _____

Emergency Contact / Relationship: _____ **Phone:** _____

Medical Information

Circle if you have a history of any of the following?

Cancer Blood Clots/Circulatory Issues

Hyper/hypotension Stroke Heart Attack

Diabetes Neuropathy Renal Dysfunction

Fibromyalgia Joint Replacement Arthritis

Osteoporosis Fractures Plantar Fasciitis

Sciatica TMJ Psoriasis Eczema

Pregnancy ____ weeks

Circle all that apply if you have experienced any of the following in the last 6 months

Back Pain: Upper Mid Low

Numbness/Tingling Strain/Sprain

Headaches/Migraines Neck Pain

Shoulder Pain Arm Pain Leg Pain

Knee Pain Wrist Pain Ankle Pain

Are you currently taking any medications?

Yes No

IF yes, please list medications

_____

_____

When was the last time you received bodywork? _____

What are your goals/expectations for this massage? _____

_____

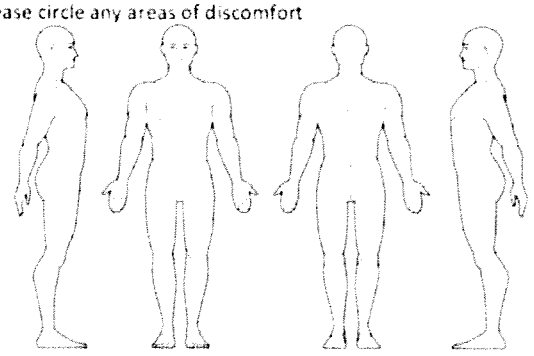
Do you have any allergies or sensitivities to lotions or oils? _____

Do you have interest in the following? Circle all that apply.

Cupping Aromatherapy CBD Oils

Hot Stone Massage Prenatal Massage

Please circle any areas of discomfort



By signing the below, I agree to the following, *I have completed this form to the best of my knowledge and agree to inform the therapist if any of the information above changes at any time.*

Signature: _____

Date: _____

Information below is to check coverage ONLY

Do you have medical insurance? Please select the coverage you have.

MEDICARE UHC TRICARE UHA HMSA BCBS HMAA PPO HMO OTHER