

Hurst Massage Therapy and Injury Rehab

1120 GRANT ROAD EAST WENATCHEE, WASHINGTON 98802 (509) 884-7163 Fax: (509) 884-2363 www.HurstClinic.com

Massage Therapy Initial Intake Form

File# _____

Name: _____
First Last MI

Date: _____

Mailing Address: _____ City _____ State _____ Zip _____

Ph#:(hm) _____ (wk) _____ (cell) _____ SS# _____ DOB: _____ Sex M F

Marital Satus: M S W D Number of Children: _____ Occupation: _____ Employer: _____

Name of Spouse/Partner _____ Emergency Contact: _____ Ph# _____

Who may we thank for referring you to us? _____ Referring doctor: _____

Ph#: _____ May we contact them if pertinent: Y/N

Will we be billing insurance for you? Yes No ID# _____ Group# _____ Ins. Co. _____

Subscriber _____ Subscriber's DOB _____ Subscriber's SS# (for billing purposes) _____

Should you enjoy your experience with us and choose to refer friends or family, we want to reward you. Of the following, which type of gift card would you most appreciate? [] Target [] Lowes [] Starbucks

Would you like to receive e-mail communication from our office? [] Yes [] No Email Address _____

In which part(s) of your body do you feel stress most often?

- head neck shoulders
 back extremities other:

Recent injuries *not* requiring surgery (including broken bones): _____

Recent surgeries with approximate dates (within the last year): _____

Please review this list and circle any illnesses and/or conditions that apply:

- | | | |
|------------------------------------------|---------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> contact lenses | <input type="checkbox"/> ruptured/bulging discs |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> heart condition | <input type="checkbox"/> pins/needles/numbness/tingling |
| <input type="checkbox"/> seizures | <input type="checkbox"/> skin disorder | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> cancer | <input type="checkbox"/> varicose veins/phlebitis | <input type="checkbox"/> infectious conditions |
| <input type="checkbox"/> stroke | <input type="checkbox"/> painful joints | <input type="checkbox"/> auto-immune disorder |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> previous MVA/trauma | <input type="checkbox"/> headache |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> fatigue/depression | <input type="checkbox"/> bruxing/grinding teeth |
| <input type="checkbox"/> other: | | |

Medications:

- | | | |
|---------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> prescription pain reducers | <input type="checkbox"/> anti-inflammatory |
| <input type="checkbox"/> over-the-counter pain reducers | <input type="checkbox"/> sleeping pills | <input type="checkbox"/> anti-anxiety/depressants |
| <input type="checkbox"/> other: | | |

Please list any vitamins, minerals, and/or herbs that you regularly take: _____

What are your goals for massage therapy? _____

Are there any areas that you would prefer *not* to be massaged?

- | | | |
|----------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> face | <input type="checkbox"/> scalp | <input type="checkbox"/> hands |
| <input type="checkbox"/> legs | <input type="checkbox"/> feet | <input type="checkbox"/> back |
| <input type="checkbox"/> arms | <input type="checkbox"/> neck | <input type="checkbox"/> chest |
| <input type="checkbox"/> abdomen | <input type="checkbox"/> buttocks | |

I agree to provide complete and accurate health information, and give notice of health changes at successive appointments as appropriate.

Massage Therapy Policy

Signature: _____ Date: _____