Massage Associates, L.L.C.

7811 L Street, Suite 270
Omaha, Nebraska 68127
402-934-1390

PATIENT INFORMATION

Name____

Address____

City____________________________ State________ Zip_____________

Phone HM (   )_____________ WK(   )___________ Cell(   )____________

Date of Birth____________________________

Emergency Contact______________________________ Relationship_____________

Phone HM(   )_____________WK(   )___________ Cell(   )_____________

Would you like to be on our mailing list? YES NO

Would you like to be on our email list? YES NO

Email: ____

Massage Associates, LLC will never sell, share or rent your contact information.

How did you hear about us? ______________________________________

Please read and sign.

I understand the cancellation policy set forth by Massage Associates, LLC. I agree to give a 24 hour notice to make any changes to my appointment or I will pay for the missed appointment time. I also understand that if I am late, my appointment will end on time and at full price.

____

Signature

Client Intake Form

Name ____

Occupation ____

CURRENT HEALTH

Have you ever received massage therapy before? Yes No Frequency: ______________

What is your primary complaint? ______________

Other areas of pain or concern? ______________

When did you first notice your primary complaint? ☐ Days ___ ☐ Weeks ___ ☐ Months ___ ☐ Years ___

What brought it on? ______________

List activities affected: ______________

Is this condition getting progressively worse? ☐ Yes ☐No

Is this condition: ☐ Constant ☐ Comes and Goes

Check any of the following that apply to your current health:

☐ pregnancy ☐ heart conditions ☐ circulatory conditions ☐ blood clots ☐ diabetes

☐ infections ☐ cancer ☐ difficult breathing ☐ arthritis

Comments: ______________

Current medications: ______________

Stress reduction/exercise activities: ______________ Frequency: ______________

PREVIOUS HISTORY

Surgeries: ______________

Accidents: ______________

Major illnesses: ______________

Is there anything I should know to ensure your comfort regarding: ______________

Allergies/Sensitivities: __ oils, __ lotions, __scents, __ detergents, other: ______________

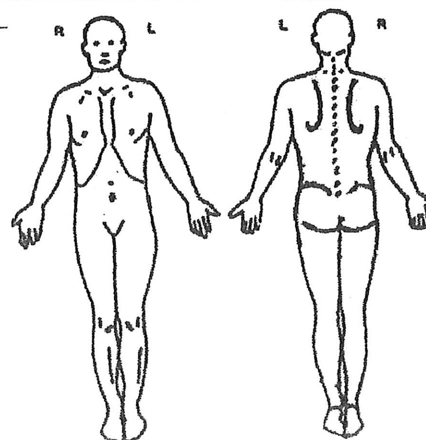
Contact lenses (the face pillow may put pressure on your eyes): ______________

Hearing abilities (communication is helpful during the session): ______________

Hair, make-up, clothes (will you return to work after your session?): ______________

Movement abilities (i.e. getting on and off the table, etc.): ______________

Comments: ______________



MARK ON FIGURES ALL AREA OF:

Pain, tenderness with O's

Numbness, tingling with ZZ's

Swelling, stiffness with X's

Scars, bruises, open wounds with HH's

RATE SEVERITY OF ALL SYMPTOM AREAS FROM 1-10

(1= I feel like a newborn baby, 10= Put me out of my misery)

1 2 3 4 5 6 7 8 9 10

CONSENT FOR CARE

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature ______________________________ Date ______________