

1343 Wantagh Avenue

Wantagh, NY 11793

(516) 679-8299

**Confidential Information**

Welcome. We want to make your visit as pleasant and comfortable as possible.

If at any time you have any questions or concerns, please let us know.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive texts: Y / N Emails: Y / N about upcoming appointments?

If you would like to receive text messages, what cellphone carrier do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received massage therapy before? Y / N - If so what type? Deep tissue? Y / N Swedish? Y / N Other? Y / N

What medication do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you consumed alcohol in the past 24 hours? Y / N

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following? Please Check

 Please Mark Area(s) of Pain

|  |  |  |
| --- | --- | --- |
| Accidents | Disk Problems | Joint Aches |
| Headaches | Lower Back Pain | Abdominal Pain |
| High Blood Pressure | Cancer | Diabetes |
| Allergies to oils/perfumes | Wear contacts or otherprosthesis | Decreased Range ofMotion |
| Stroke | Colitis | Whiplash |
| Varicose Veins | Heart Attack | Mid Back Pain |
| Surgery | Seizures | Arthritis, bursitis, gout  |
| Broken Bones | Nervous Tension | Breast augmentation |
| Neck Pain | Sprains | HIV |
| Fibromyalgia | T.M.J. | Other |

Do you have any of the following today?

|  |  |
| --- | --- |
| Sunburn | Inflammation |
|  Severe Pain | Headache |
| Open Cuts, bruises, burns | Irritated Skin Rash |
| Poison Ivy | Cold/Flu |

 Is there anything else that we should know?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand 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 hour. If this office is submitting paperwork to my insurance carrier, I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the Licensed Massage Therapist or office listed above, for services tendered.

**Signature Date**