ALINEA
Natural Health

Massage Intake Form

Confidential Health History

TODAY'S DATE: _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Mailing Address: _____
City: _____ **State:** _____ **ZIP:** _____
Email Address: _____
Phone Numbers:
☐ Home: _____ ☐ Mobile: _____ ☐ Work: _____
Date of Birth: _____ **Age:** _____
Parent/Guardian Signature + Printed Name & Relationship (REQUIRED IF UNDER 18):

Occupation: _____ **Employer:** _____

Emergency Contact
Name & Relationship: _____
Phone: _____

How did you hear about us?
☐ Existing Client ☐ Gift Certificate ☐ Medical Referral ☐ Social Media ☐ Other: _____

Massage History
Is this your first massage? ☐ Yes ☐ No
How long since your last massage? _____
What amount of pressure do you prefer? ☐ Light ☐ Medium ☐ Deep
Are there any areas you *do not want massaged* (feet, abdomen, face, etc.?) _____
What are your goals or expectations for today's session? _____

Important Information

- Your late arrival may result in reduced treatment time – with no reduction in price.
- Please turn off or mute all electronic devices while in the building.
- Our massage tables have a working load capacity of **400 lbs.** Please let us know if this will be an issue.

- **Medical History**
  Do you have a **history** of any of the following? (Check all that apply)

☐ Abdominal Pain	☐ Accident (Date:)	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Athlete's Foot
☐ Back Pain	☐ BLOOD CLOTS	☐ Breast Augmentation (Date:)
☐ Cancer (Date:)	☐ Broken Bones	☐ Bursitis
☐ Chronic Cough	☐ Carpal Tunnel	☐ Colitis
☐ COVID-19	☐ Decreased Range of Motion	☐ Depression
☐ Diabetes	☐ Eczema	☐ Edema / Swelling
☐ Fibromyalgia	☐ Hemophilia	☐ Gout
☐ Headaches	☐ Heart Attack	☐ Hepatitis
☐ High Blood Pressure	☐ HIV / AIDS	☐ IBS
☐ Joint Ache	☐ Implants	☐ Kidney Disease
☐ Lupus	☐ Lyme Disease	☐ Mastectomy
☐ Osteoporosis	☐ MRSA	☐ Multiple Sclerosis
☐ Psoriasis	☐ Palsy	☐ Neck Pain
☐ Scoliosis	☐ Prosthesis	☐ PHLEBITIS
☐ Shoulder Pain	☐ Seizures	☐ Sciatica
☐ Sinusitis	☐ Spinal Stenosis	☐ Shingles
☐ STAPH INFECTION	☐ STROKE	☐ Sprains
☐ Thoracic Outlet Syndrome	☐ Tuberculosis	☐ Surgery (List with Dates below)
☐ Vertigo	☐ Whiplash	☐ Varicose Veins

- **Other/Details:** _____

Surgery History:

_____

Allergies

☐ None Known ☐ Yes: _____

Currently Taking Medications & Supplements? List if Yes:

☐ No ☐ Yes: _____

Current Pregnancy?

☐ No ☐ Yes – Due Date: _____

Do any of the following apply to you TODAY?

(Please also inform us at future appointments if any apply.)

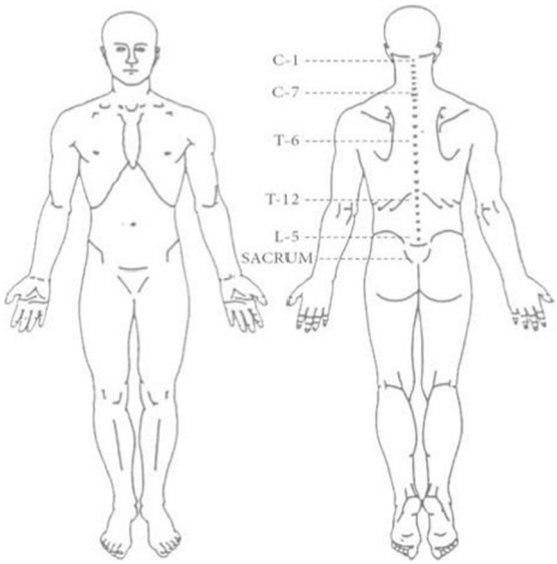
☐ Cold/Flu ☐ Fever ☐ Incontinent Bladder/Bowel ☐ Inflammation

☐ Irritated Skin/Rash ☐ Medicated Skin Patch ☐ Recent Immunization (24 hrs.)

☐ Severe Pain ☐ Sunburn ☐ TAKING PAIN MEDICATION

☐ Other: _____

Pain or Discomfort Map: Please indicate with an "X" any areas where you are currently feeling pain or discomfort.



Appointment Cancellation Policy

We ask for a 24 hour minimum notice cancel or reschedule an appointment.

- **No-Show Policy:** If you neglect to call to cancel, a **50% deposit** will be required for all future appointments.
- A **50% Deposit** is required for online bookings and select appointments.

Acknowledgment

I confirm that the information provided herein is true and accurate to the best of my knowledge. I understand that massage therapy is not a substitute for medical care and that no diagnosis will be made. I consent to the use of my confidential health information for the specific purpose of providing treatment to me and for general administrative operations of **Alinea Natural Health, PMA.**

I have read, understand, and agree to abide by the terms of **Alinea's Appointment Cancellation Policy** as stated above and understand that **payment is due when services are rendered** and in compliance with said policy.

✓ **Signature:** _____

✓ **Date:** _____