HARMONY
HEALING ROOM

NO FAULT INTAKE FORM

Basic Personal Information		
First Name:	Last Name:	Date of Birth:
Address:		
Best Contact Phone Number:		Insurance Policy #:
Email:		
Emergency Contact Name and Number		
Lawyer contact info, if applicable:		
Referring Doctor:		Date of Injury:
Insurance Company Name:		Insurance Billing Address
ID/Claim Number:		Insurance phone #:
Case Manager:		Name of Insured: Self or other:

General Health		
Please list all allergies:		
Are you currently under the care of any: ☐ Doctors ☐ Chiropractors ☐ Physical Therapists ☐ Other medical professional	List any surgeries in the past 5 years:	Surgeries older than 5 years:
Are you pregnant? Y/N	If yes, what trimester are you in?	Do you smoke?

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List all medications and herbs:
Do any of these conditions apply to you? □ High Blood Pressure □ Low Blood Pressure □ Heart Condition □ Heart Attack □ Fibromyalgia □ Headaches □ Diabetes □ Blood Clots □ Stroke □ Depression □ Nerve Pain □ Eczema or Psoriasis □ Cancer □ Sprains/Strains □ Broken Bones □ Diabetes □ TMJ □ Arthritis □ Whiplash
Any additional medical information we should know? (Ex: pacemaker, insulin pump, etc.)

Health Today
Are you experiencing any pain or discomfort today? Please describe:
Is your pain: sharp, dull, achy, deep, tingling, new, ongoing?
Are you taking any extra medications today? (Ex: pain killers, cold medication)

General Massage	
Have you ever had a massage before?	If yes, how often? □ Once □ A few times □ Yearly □ Monthly □ Weekly □ Other (please specify)
If you do not get massage regularly what is stopping you from doing so? □Time □Cost □Not a priority □ Other_____	
What is your primary goal for the session?	
Do you have any sensitivity to scent?	Have you ever used essential oils :
Is there any area of the body you prefer we avoid in general? (Ex: feet or scalp)	

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Confidentiality Acknowledgement

All the information provided to the therapist is strictly confidential. The therapist will not disclose any information to anyone including a medical practitioner unless you give explicit consent to do so.

Treatment Terms and Consent

You are consenting to be treated by the therapist and agreeing to the following conditions:

• I have provided an accurate medical history to the best of my knowledge.
• I understand that a massage therapist cannot diagnose illness or disease and cannot prescribe medications.
• I understand that this treatment is for therapeutic purposes only and any misconduct will bring the session to an immediate end.
• The treatment provided to me is intended to improve my wellness but is not a substitute for medical treatment.
• The therapist has the right to refuse treatment if she believes it is not safe for herself or for me.
• I agree to notify my therapist of any changes to my physical and mental condition during treatment.

Signature: _____ Date: _____

Cancellation policy

As time is valuable to both of us, I agree that should I need to cancel my appointment, I will do so at least 24 hours prior to my appointment or I will be billed an early cancellation fee of $25. Accommodations may be available for true emergencies. We value your time too! Should my therapist need to cancel within less than 24 hours I will receive a $25 credit towards my next massage.

Signature: _____ Date: _____