BEST HEALTH OPTION

ACUPUNCTURE & WELLNESS

MASSAGE INTAKE FORM

W177 N9856 Rivercrest Drive
Germantown, WI 53022

262.293.4493

besthealthoption.co

Name: _____ Phone #: _____

Date of Birth: _____ Email: _____

Occupation: _____

How did you hear about Best Health Option? _____
(Word of mouth, Internet, Flyer, ad/article)

What are the reasons for your visit today? _____

How do you alleviate stress or pain?_____

Describe any cuts, bruises, or injuries you currently have:_____

Describe surgeries you have had:_____

List all conditions currently monitored by a Health Care Provider: _____

List any medications that you took today: _____

Please check all current and previous conditions:

☐ Headache	☐ Disc problems	☐ Blood clots
☐ Sleep problems	☐ Spasms/cramps	☐ Stroke
☐ Fatigue	☐ TMJ (jaw pain)	☐ Heart disease
☐ Flu or cold symptoms in the last 48 hours	☐ Tendonitis/bursitis	☐ High/low blood pressure
☐ Sinus	☐ Spinal problems	☐ Poor circulation
☐ Allergies to scents or lotions	☐ Varicose Veins	☐ Asthma
☐ Allergies, in general	☐ Stiff/painful joints	☐ Thyroid dysfunction
☐ Arthritis	☐ Neck, shoulder, or arm pain or numbness	☐ Diabetes
☐ Osteoporosis	☐ Low back, hip or leg pain or numbness	☐ Currently pregnant
☐ Scoliosis	☐ Sciatica	☐ Malignant cancer or tumors
☐ Broken bones	☐ Depression	☐ Benign cancer or tumors

Describe, as needed any conditions indicated above,
or other conditions that you feel may be important. _____

Consent for care: It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Consent it treat a minor child or disabled dependent:

I authorize _____ and whomever he/she designates as assistants to administer care as deemed necessary to my _____ (relationship) Patients name _____.

Adult's/guardian's signature_____ Date_____ Time _____

Patient signature _____ Date _____ Time_____

Practitioner/witness signature _____ Date _____ Time_____