Balance Me Massage

Megan Krein, LMT  Oregon License #20674

Massage Client Intake Form

Personal Information		
Name:		Date:
Address:		
City:	State:	Zip:
Phone:	Email:	
DOB:	Age:	
Sex:	Height:	Weight:
How did you hear about Balance Me Massage?		
Emergency Contact		
Name:	Phone:	
Relationship:	Is it okay to leave a message at this number?	
Medical Contact		
Physician's Name:		Phone:
Medical Practice Name:		
Insurance Information		
Insurance Company:		Phone:
Insurance's Mailing Address:		
City:	State:	Zip:
Policy #:	Group #:	
Adjuster's Name:	Claim #:	Date of accident/injury:

History

Are currently taking any medications? ☐ Yes ☐ No
If so, what are they?

Are you currently under a physician's care? ☐ Yes ☐ No
If so, for what?

Are you currently pregnant? ☐ Yes ☐ No If so, how far along?

Please provide medical history for the past 5 years for any surgeries, major illnesses, or injuries. Please provide dates and treatments received.

Date	Incident	Treatment(s) Received

What do you do for a living?

What activities do you participate in (i.e. sports)?

What is your major complaint today? Rate it (mild/moderate/severe):

Have you received a professional massage before?

Do You Have Any of the Following Today? (Check all that apply)

☐ Allergies	☐ Contact lenses	☐ Epilepsy	☐ Injury/ illness
☐ Arthritis/joint swelling	☐ Contagious disease	☐ Fibromyalgia	☐ Osteoporosis
☐ Asthma	☐ Cuts, burns, bruises	☐ Headache / migraine	☐ Pregnancy
☐ Blood pressure (H/L)	☐ Depression	☐ Heart condition	☐ Sensitive skin
☐ Broken bones	☐ Diabetes	☐ Heart Disease	☐ Skin problems
☐ Cancer (_____)	☐ Dizziness	☐ Hemophilia	☐ Varicose Veins
☐ Circulation problems	☐ Easy bruising	☐ Inflammation	☐ Other

Revised 9/23/2019

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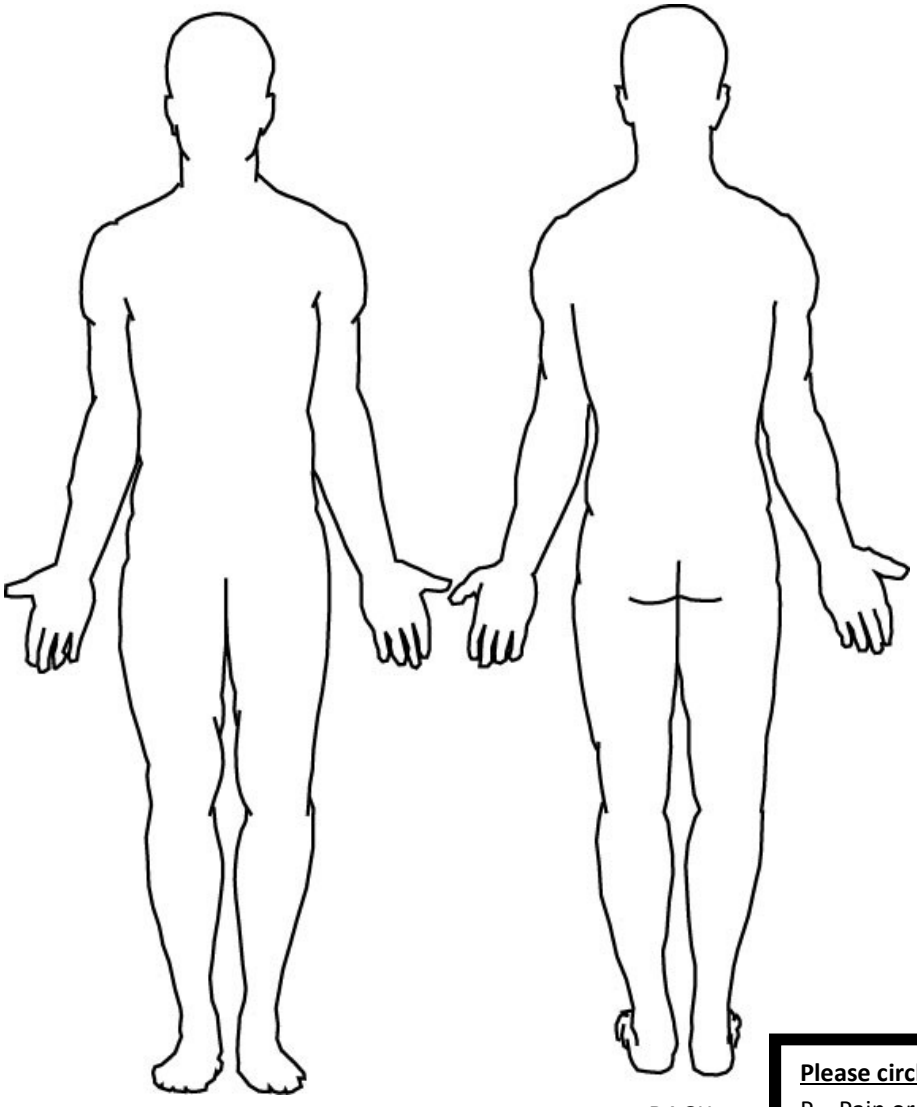
HEALTH INFORMATION



FRONT BACK

Please circle location of pain:
P = Pain or tenderness
S = Joint or muscle stiffness
N = Numbness or tingling

FINANCIAL OBLIGATION - This office gladly prepares insurance forms and reports, however this does not guarantee payment by insurance. Therefore, all professional services rendered are the sole responsibility of the patient/guarantor. Signing below indicates you accept full responsibility for all payments due for services rendered by our office and staff.

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Signature	Relationship to Patient	Date