Lake Grove Wellness

New Client Intake Form

Patient Name (First and Last) _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Phone _____ Occupation _____

Medical Information:

Do you have any allergies?_____

Are you currently taking and medications? _____ Yes _____ No

If yes, please list name and reason for medication:_____

_____

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list their name and reason for treatment:_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

☐arthritis ☐diabetes ☐blood clots
☐broken/dislocated bones ☐bruise easily ☐cancer ☐chronic pain
☐hepatitis (A,B,C, other) ☐skin condition
☐stroke ☐recent surgery
☐TMJ ☐depression
☐diverticulitis ☐headaches/migraines
☐heart condition ☐back problems
☐high blood pressure ☐insomnia
☐muscle strain/sprain
☐scoliosis ☐seizures ☐whiplash
☐pregnancy

If any of the above needs to be detailed, please share:_____

_____

_____

How did you hear about Lake Grove Wellness?_____

Massage Information:

Have you ever received massage therapy? _____ Yes _____ No

What type of massage are you seeking? ☐Relaxation ☐Therapeutic/Deep Tissue ☐Sports

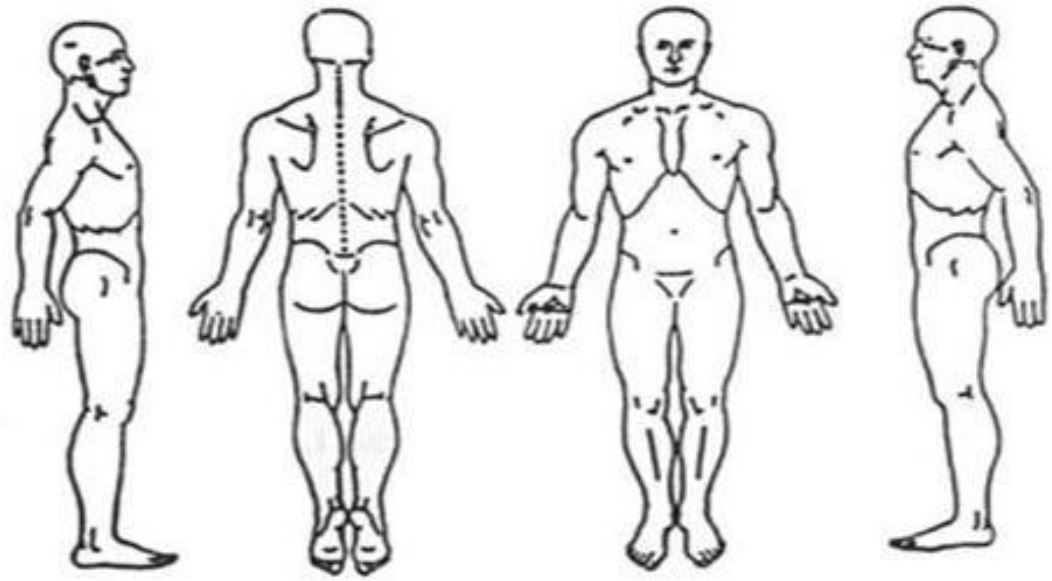
What pressure do you prefer? ☐Light ☐Medium ☐Deep

Are there any areas you do not want massaged?_____

What are your goals for this treatment session?_____

_____

Please circle any areas of discomfort:



Explain any conditions you have marked above:_____

_____

_____

By signing below you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Your appointment time is reserved exclusively for you. Please be on time. Please cancel 24 hours in advance of that time to avoid a cancellation fee. The cancellation fee amount is at the discretion of Lake Grove Wellness.

Client Signature _____ Date _____

Therapist Signature _____ Date _____