COMPLEMENTS FOR HEALTH
Patient Intake Form

Name_____Date_____
Address_____City/Town_____
State_____Zip Code_____Phone_____Email_____
Date of Birth_____Occupation/Recreation_____
Referred by_____Medications_____
**In the past 24 hours: Have you had a fever of 100 degrees or above, or had respiratory/flu-like symptoms?_____Have you been in contact with anyone in the past 14 days who was diagnosed with COVID-19 or who has coronavirus-like symptoms?_____

Do you have a history of the following?

Allergies/Sinus Problems	Diabetes	Pregnant (Currently)
Arthritis/Bursitis	Depression	Phlebitis
Asthma	Headaches/Migraines	Osteoporosis
Anxiety/Stress	Dizziness/Vertigo/Fainting	Surgery
Accident	Fatigue	Scoliosis
Blood Pressure/Heart Issue	Fibromyalgia	Seizures/Epilepsy
Cancer	Lyme/Tick-borne Disease	Sciatica
Chest pain	Muscle Strain/Sprain	Tendinitis
Constipation	Neck pain	Varicose Veins
Disc Herniation	Poor circulation	Whiplash

Have you had professional massage before?

Do you have an allergy or sensitivity to oils, lotions, or scents?

Please describe any specific areas of pain and tension, incl. type of discomfort:

POLICIES: Payment is due when services are rendered, unless arrangements for the acceptance of insurance are made (such as VACCN). Booking an appointment reserves that time for your individual session. If you are unable to keep that appointment, please notify us within 24 hours so that time can be used by another patient/client. If you arrive late for a scheduled session, you will receive treatment for the remaining time.

By signing below, I acknowledge that I have read and understand the above policies, and that the therapy provided is not a substitute for medical care, and that it is recommended that I am concurrently working with my Primary Caregiver for any condition that I may have. I have stated all my known medical conditions and will keep the therapist updated on any changes.

I recognize and accept that this therapy involves physical touch and close proximity to the therapist for an extended period of time, and may therefore elevate the risk of disease transmission such as COVID-19.

Signature_____Date_____