Hurst Massage Therapy and Injury Rehab
1120 GRANT ROAD EAST WENATCHEE, WASHINGTON 98802 (509) 884-7163 Fax: (509) 884-2363 www.HurstClinic.com

Massage Therapy Initial Intake Form

File#_____

Name:_____ Date:_____
First Last MI

Mailing Address:_____City_____State_____Zip_____
Ph#:(hm)_____(wk)_____(cell)_____SS#_____DOB:_____Sex M F
Marital Satus: M S W D Number of Children:____Occupation:_____ Employer:_____
Name of Spouse/Partner_____Emergency Contact:_____Ph#_____
Who may we thank for referring you to us?_____Referring doctor:_____
Ph#:_____ May we contact them if pertinent: Y/N
Will we be billing insurance for you? Yes ☐ No ☐ ID#_____Group#_____ Ins. Co._____
Subscriber_____ Subscriber's DOB_____ Subscriber's SS# (for billing purposes)_____

Would you like to receive e-mail communication from our office? [ ] Yes [ ] No Email Address_____

In which part(s) of your body do you feel stress most often?

- ☐ head
- ☐ neck
- ☐ shoulders
- ☐ back
- ☐ extremities
- ☐ other:

Recent injuries *not* requiring surgery (including broken bones):_____

Recent surgeries with approximate dates (within the last year):_____

Please review this list and circle any illnesses and/or conditions that apply:

- ☐ diabetes
- ☐ arthritis
- ☐ seizures
- ☐ cancer
- ☐ stroke
- ☐ scoliosis
- ☐ loss of balance
- ☐ other:
- ☐ contact lenses
- ☐ heart condition
- ☐ skin disorder
- ☐ varicose veins/phlebitis
- ☐ painful joints
- ☐ previous MVA/trauma
- ☐ fatigue/depression
- ☐ ruptured/bulging discs
- ☐ pins/needles/numbness/tingling
- ☐ high blood pressure
- ☐ infectious conditions
- ☐ auto-immune disorder
- ☐ headache
- ☐ bruxing/grinding teeth

Medications:

- ☐ muscle relaxants
- ☐ over-the-counter pain reducers
- ☐ other:
- ☐ prescription pain reducers
- ☐ sleeping pills
- ☐ anti-inflammatory
- ☐ anti-anxiety/depressants

Please list any vitamins, minerals, and/or herbs that you regularly take:_____

What are your goals for massage therapy?_____

Are there any areas that you would prefer *not* to be massaged?

- ☐ face
- ☐ legs
- ☐ arms
- ☐ abdomen
- ☐ scalp
- ☐ feet
- ☐ neck
- ☐ buttocks
- ☐ hands
- ☐ back
- ☐ chest

I agree to provide complete and accurate health information, and give notice of health changes at successive appointments as appropriate.

☐ Massage Therapy Policy

Signature:_____Date:_____