OFFICE
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Email
krissylindquist1@gmail.com

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____
PHONE: _____EMAIL: _____
OCCUPATION: _____ EMPLOYER: _____
HEALTH INSURANCE CO: _____
GROUP #: _____ ID #: _____

HOW DID YOU HEAR ABOUT ACHIEVE?
GOOGLE __ YELP __ FRIEND __ FAMILY __ OTHER __

IS THIS YOUR FIRST MASSAGE? YES NO

HAVE YOU HAD ANY ILLNESSES, SURGERIES, ACCIDENTS, OR INJURIES THAT MAY STILL BE AFFECTING YOU? IF YES, PLEASE PROVIDE DATES AND DETAILS:

PLEASE INDICATE IF YOU HAVE OR HAVE HAD AND OF THE FOLLOWING CONDITIONS:

___ JOINT PROBLEMS ___ DIABETES
___ BACK PROBLEMS ___ OSTEOPOROSIS
___ LYMPH NODE REMOVAL ___ VARICOSE VEINS
___ HIGH BLOOD PRESSURE ___ HEART CONDITIONS
___ IRRITABLE BOWEL SYNDROME OR DIGESTIVE PROBLEMS
___ BLOOD CLOTS ___ HEPATITIS OR LIVER ISSUES
___ KIDNEY PROBLEMS ___ SKIN RASH OR DISORDER
___ HIV OR AIDS ___ CANCER
___ PREGNANCY ___ DIFFICULTY BREATHING
___ ALLERGIES/SENSITIVITIES: _____
___ CHRONIC PAIN IF SO, WHERE? _____

ANY OTHER MEDICAL CONDITIONS NOT LISTED? _____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? PLEASE LIST:
_____
REASON FOR TODAYS VISIT: ___ SPECIFIC INJURY TREATMENT ___ RELAX
___ STRESS REDUCTION ___ PRE/POST-EVENT TREATMENT ___ OTHER

Consent for care:

I have read and understand this intake from and have completed it to the best of my knowledge and consent to this massage therapy session. I understand that massage therapy is a therapeutic health aid for the purpose of stress reduction and relief from muscular tension and is non-sexual. I understand that massage therapist do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examinations or diagnosis, and that it is recommended that I see a Primary Health Care Provider for any physical ailment I may have.

Cancellation & payment policy:

In consideration of my fellow patients and massage practitioner, I understand that a minimum of 24 hours notice is required to change or cancel an appointment. I further acknowledge that I will be held responsible for the full cost of the session should I cancel, miss or reschedule within the 24-hour time period. Payment for service is due at the time of service, unless otherwise arranged with the practitioner. The client is responsible for payment even if an insurance company is billed. In the event service is denied by insurance, the client agrees to pay for the service in full.

I agree to abide by this policy.

Signature: _____ Date: _____