Arête Massage Tucson's Intake Form

Full Name ____________________________________ Birthday ___ /___ /____ Age ______ Gender □ M □F □TG
Address ______________________________________ City/State/Zip _______________________________________
Telephone # Hm (   ) _____ -_______ Cell (   ) _______ ---________ Wk (   ) _______ ---____________
Occupation__________________________ Marital/Relationship Status ___________________________________
Email ______________________________ Date of Injury: ____/____/____
Referred By? (Massamio, Friend, Spouse, Health Care Physician) _______________________
In Case of Emergency Contact _______________________________ Phone (   ) _______ ---____________
Preferred method of communication: Phone Text Email Other _________________________
Ok to text appointment reminders? Yes___ No ___ (txt charges may apply)
Do You have a primary health care provider? □Yes □No PCP Name _______________________________

General and Medical Information

Y N Have you ever had a professional massage? If yes, how often? ___________________________________
Y N Are you pregnant? If yes, how far along are you? ____
Y N Are you sensitive to touch/pressure in any area? (ticklish? Where?)______________________________
Y N Preference for pressure? Light Moderate Firm Deep
Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:
____
Y N Are you under doctor's care for any health condition (New or Old injury/disease/depression)?
If so, what? ____

List of current medications and reasons:

Medication	Time Administered /Frequency	Reason

List of surgeries/Injuries:

Area	Date	Explanation/Reason

Indicate Areas of Pain/Tension:
On a scale from 1 - 10, 10=highest, rate your levels of:
Stress _________ Pain _________ Energy _________
When did your symptoms begin?
Year: Month: Explaination: ____
What have you done for relief?
____
Is the condition getting better/worse? (Circle one)
Signature: ______________________________________ Today's Date:___________________________