new client intake

Fox Massage LLC 1829 NE Alberta St 97211 & 1920 NW Lovejoy St 97209
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Name: ______________________________________ Date of Birth: _____ / _____ / _____
Home Address (street, city, zip): ____
Phone: ________________________________ Email: _____________________________
Occupation: _____________________________ Employer: __________________________
Health Insurance Co: _________________ Provider Cust. Service Phone #: _______________
Group Number: __________________________ ID Number: __________________________
In Case of Emergency, Contact: Name: __________________________ Relationship: _______
Phone: _______________ How did you find us? __________________
Is this your first professional massage? Yes No
Have you had any illnesses, surgeries, accidents or injuries that may be still affecting you?
If so, please provide dates and details of the incident(s): ________________________________
____

Please indicate if you have or have had any of the following conditions:

____ Joint Problems
____ Back Problems
____ Lymph Node Removal
____ High Blood Pressure
____ Heart Condition
____ Blood Clots
____ Kidney Problems
____ HIV or AIDS
____ Cancer
____ Osteoporosis
____ Diabetes
____ Varicose Veins
____ Chronic Pain: if so, where? _______________
____ MRSA
____ Irritable Bowel or Digestive Issues
____ Hepatitis or Liver Issues
____ Skin Rash or Disorder
____ Allergies/Sensitivities: ___________________

Any other medical condition(s) not listed? ____
Are you currently taking any medications? Please list: _________________________________
Do you have specific likes and/or dislikes regarding massage? ___________________________
What is your primary goal for today's session? ____

Cancellation and 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, unless I send someone in my place. Payment is due at the time of service unless otherwise arranged with the practitioner. Third party billing will be charged at a rate of $40-50 per 15 minute increment. The client is responsible for payment even if an insurance company is billed. In the event service is denied by the insurance company, the client agrees to pay for services in full. I agree to abide by this policy.

Signature ____________________________ Date _________