**The Center For Whole Body Wellness**

**Patient Intake Form**

Patient Name: Date:

Patient Address:

City: State: Zip:

Home Phone: Cell Phone:

Birth date: Age: Sex: M F

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Information:**

Patient Employer: Occupation:

Employer Address:

City: State: Zip

Work phone: Cell Phone:

**Current Medications:** (Including Ibuprofen, aspirin, natural remedies)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Medication | Dosage |
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|  |  |  |  |

**List surgeries, accidents/injuries and major illnesses:**

|  |  |
| --- | --- |
| Surgery, accident/injury or major illness | Date |
|  |  |
|  |  |
|  |  |

Have your ever received a professional massage? No \_\_ Yes\_\_\_ If yes, frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What areas do you feel need to be addressed? ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any areas of your body you WOULD NOT want massaged? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a health care practitioner? No \_\_\_ Yes \_\_\_

If Yes, please list

Practitioner name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Family Physician: Phone:

Insurance Information: Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any medical concerns? Please List:

**In Case of Emergency:**

Name: Relationship: Phone: