Indiana Reproductive Acupuncture

Patient Intake Form

Contact Information
Massage

12188-A North Meridian, Suite 225 I Carmel, IN 46032 I **317.846.8777** I Fax 317.846.8834 I www.IndianaReproductiveAcupuncture.com

NAME	DATE

AGE	DATE OF BIRTH	SEX
		❑ MALE ❑ FEMALE

HOME ADDRESS		
CITY	STATE	ZIP

CELL PHONE	HOME PHONE	WORK PHONE

WHAT IS THE BEST DAY TIME PHONE NUMBER TO REACH YOU?	MAY WE CALL YOU AT WORK?
❑ CELL PHONE ❑ HOME PHONE ❑ WORK PHONE	❑ YES ❑ NO

E-MAIL ADDRESS	IS E-MAIL A GOOD WAY TO CONTACT YOU?
	❑ YES ❑ NO

EMPLOYER	OCCUPATION

SPOUSE/PARTNER NAME		
EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT US? (Doctor's name, Nurse, Doctor office staff, website, brochure, friend, etc)	DO WE HAVE PERMISSION TO SEND THANK-YOU TO REFERRAL SOURCE?
	❑ YES ❑ NO

CONSENT FOR MASSAGE

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage/bodywork is performed differently under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to update my practitioner as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so.

Quality patient care is our primary concern. The optimum timing of your treatment is an important aspect of that care. If it is necessary to reschedule your appointment, we ask to be given 24 hours notice. We understand that sometimes scheduling conflicts arise that are unavoidable but we ask that you give us a 24 hour notice to avoid a $50 cancellation fee.

Signed: _____ **Date:** _____

Appointments cancelled less than 24 hours in advance will be charged a fee

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NAME

WHAT IS YOUR PREVIOUS MASSAGE EXPERIENCE? _____

WHAT IS YOUR REASON FOR CHOOSING MASSAGE THERAPY AND WHAT RESULT DO YOU EXPECT? _____

WHAT ARE YOUR EXCERCISE HABITS? _____

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ❑ Allergies (foods, medications, nuts, etc)
- ❑ Arthritis
- ❑ Anxiety/Depression
- ❑ Bleeding/Bruising
- ❑ Blood Pressure Problems
- ❑ Bursitis
- ❑ Cancer
- ❑ Cardiac Issues
- ❑ Circulation Problems
- ❑ Dizziness
- ❑ Hernia
- ❑ Headache
- ❑ Joint Problems
- ❑ Muscle strain/Sprain
- ❑ Phlebitis/Blood Clots
- ❑ Pregnancy _____ wks
- ❑ Recent Surgery
- ❑ Respiratory Problems
- ❑ Seizures/Epilepsy
- ❑ Sinus Problems
- ❑ Stress
- ❑ Varicose Veins
- ❑ Vertebral Disc Problems
- ❑ Other:_____

Thank you for filling out this form so that we can better serve your health needs. All information will remain confidential.