

Limp In

Leap Out

**BALLARD HEALTH CENTER**  
AND WELLNESS SPA  
**CONFIDENTIAL CLIENT INTAKE FORM**

Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone: home (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_ work (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How were you referred?  Walk/Drive by  Internet Search  City Search  Craigslist  
 Newspaper/Print Friend: \_\_\_\_\_ Other: \_\_\_\_\_

Is this your first massage? Yes  No  Reason for your visit: \_\_\_\_\_

Please list any major illnesses, surgeries, injuries, or hospitalizations in the past 5 years: \_\_\_\_\_

Please check the following:

- |  |  |   |
|--|--|---|
| Yes No   | Yes No   | Yes No  |
| <input type="checkbox"/> <input type="checkbox"/> Contact Lenses       | <input type="checkbox"/> <input type="checkbox"/> Pregnancy          | <input type="checkbox"/> <input type="checkbox"/> Localized Infection |
| <input type="checkbox"/> <input type="checkbox"/> Communicable Illness | <input type="checkbox"/> <input type="checkbox"/> Acute Inflammation | <input type="checkbox"/> <input type="checkbox"/> Fever               |

Do you now have or have you had any of the following within the past 3 years?

- |   |  |  |
|---|--|--|
| Yes No  | Yes No   | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Problems              | <input type="checkbox"/> <input type="checkbox"/> Thrombosis/Embolism        | <input type="checkbox"/> <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol/Caffeine Abuse | <input type="checkbox"/> <input type="checkbox"/> Ovarian/Menstrual Problems | <input type="checkbox"/> <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> <input type="checkbox"/> Skin Disorders              | <input type="checkbox"/> <input type="checkbox"/> Bursitis/Joint Disorders   | <input type="checkbox"/> <input type="checkbox"/> Hay Fever/Allergies    |
| <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure     | <input type="checkbox"/> <input type="checkbox"/> Phlebitis/Varicose Veins   | <input type="checkbox"/> <input type="checkbox"/> Chronic Illness/Pain   |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems       | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis/Lumbago/Gout      | <input type="checkbox"/> <input type="checkbox"/> Sciatica                   | <input type="checkbox"/> <input type="checkbox"/> Migraines/Headaches    |
| <input type="checkbox"/> <input type="checkbox"/> Ulcerated Colon             | <input type="checkbox"/> <input type="checkbox"/> Neck/Spinal Injury         | <input type="checkbox"/> <input type="checkbox"/> Kidney/Bladder Ailment |

Insurance Information (for insurance clients only)

Insurance Company: \_\_\_\_\_ Claim # \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Adjuster's Phone: (\_\_\_\_) \_\_\_\_\_

I understand that if my insurance does not pay for my treatments, I am responsible for payment: \_\_\_\_\_ initials

Are you currently under the care of a healthcare professional? Yes  No

Name: \_\_\_\_\_ Title/Specialty: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please list any medications taken at regular intervals: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

*The above information is true and accurate to the best of my knowledge. Unless covered by a pre-arranged insurance claim, I agree to pay for my massage treatments by cash or check at the time of treatment. I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental condition. I am clear that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health. I understand that Ballard Health Center and Wellness Spa requires 24 hours notice if I need to cancel my appointment.*

Signature \_\_\_\_\_ Date \_\_\_\_\_