Russo Neuromuscular Massage Center

1145 Reservoir Avenue Suite 210, Cranston, RI 02920

Confidential Health Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

DOB: _____ Phone (Circle one: cell, home, work): _____

Emergency Contact/Relation: _____ Phone: _____

Occupation: _____ Referred by: _____

Employer: _____

Have you received massage therapy in the past? _____ If yes, which type? (Swedish, Deep Tissue, Neuromuscular Therapy, Sports, Other?_____

What is the reason you are seeking massage therapy? _____

List activities and movements that trigger the symptoms:_____

_____

List activities & movements that help relieve symptoms:

_____

_____

List past surgeries, health conditions, accidents, and/or injuries you have had in the past:

_____

_____

_____

Are you pregnant? (Y or N) If yes, how many weeks? _____

Do you have any allergies? (Seasonal, environmental, food, and/or medications): _____

_____

List all medications you are taking, including over-the-counter items and vitamins:

_____

_____

_____

Informed Consent

I have completed this health intake form accurately and to the best of my knowledge. I understand the treatment here is not a replacement for medical care and the therapist/practitioner does not prescribe medical treatment. I understand that the treatment is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental conditions I may have. I agree to inform the therapist of any health changes including medications and recommendations made to me by my medical physician or other health care professional. I agree to keep the therapist up to date with any injury/accident occurrences. I give my consent to receive massage therapy and agree to inform the therapist if I have any discomfort or pain during or after the treatment and will consult on any questions or concerns I have immediately. I enter into treatment in good faith, realizing that as a licensed massage therapist, the therapist will practice within the guidelines set down by their professional training and the State of Rhode Island.

I understand that payment is due at the time of treatment unless previous arrangements have been made.

I agree to provide at least a **24-hour** notice to cancel or change an appointment. If I fail to do so, I agree to pay the **full** session fee.

Signature _____ Date_____