PEAK PERFORMANCE MASSAGE

6502 GRAND TETON PLAZA, SUITE 101 | MADISON, WI 53719 | 608.770.2081
190 GARDNER AVENUE, SUITE 9 | BURLINGTON, WI 53105 | 262.758.6228

CLINICAL HEALTH INTAKE FORM

Personal Data

Name: _____ Date:_____Referred By:_____

Address: _____ Phone: (cell, home, work) _____

City: _____ State: _____Zip: _____ Phone: (ceIl home work) _____

Email: _____ Date of Birth: _____

Occupation/Employer: _____

_____

Primary Care Provider: _____ Phone: _____

May we consult with your primary care provider? Please initial if yes: ❑ Yes _____ ❑ No

Emergency contact: _____ Phone: _____

Massage History/Treatment Information

Have you eyer received a professional massage? ❑ Yes ❑ No If yes, date of last massage: _____

What results do you want from your sessions? _____

_____

Prioritize areas of your body that you prefer to be massaged? _____

_____

Please check any areas of your body where: you prefer not to receive massage:
❑ Head ❑ Face ❑ Neck ❑ Arms ❑ Chest ❑ Abdomen ❑ Back ❑ Buttocks ❑ Legs ❑ Feet ❑ Other:

Are you currently seeing a health care practitioner? ❑ Yes ❑ No If yes, please explain _____

_____

Are you currently seeing a Counselor, Psychotherapist, or a Support Group? ❑ Yes ❑ No If yes, please explain _____

_____

List stress Reduction and Exercise Activities. Please indude frequency;_____

_____

_____

List current Medications, Herbals & Supplements and reason for use. Please Include OTCs such as Aspirin, Ibuprofen, Clairitin, etc. _____

_____

_____