Nick OF TIME
THERAPEUTIC MASSAGE

1105 SW Crestview, Pullman WA 99163 (509) 332-9492

Massage Intake Form

PATIENT INFORMATION

Date: _____________ Last Name: ________________________ First Name: ________________________ Middle Initial: _____

Address: __________________________ City: ___________________ State: _____ Zip: ___________ D.O.B: ______________

Phone: (Primary) _____________________ (Secondary) _____________________ Email: _____________________________

Emergency Contact: __________________________ Relationship: _____________________ Phone: ____________________

HEALTH INFORMATION

Insurance Provider: __________________________ Phone: ___________________ Policy Number: _____________________

Primary Health Care Provider: ______________________________ Address: ____

City: ______________________________ State: _________________ Zip: ____________ Phone: _________________________

Surgeries/Injuries/Major Illnesses: (Please list approximate dates and treatments received:

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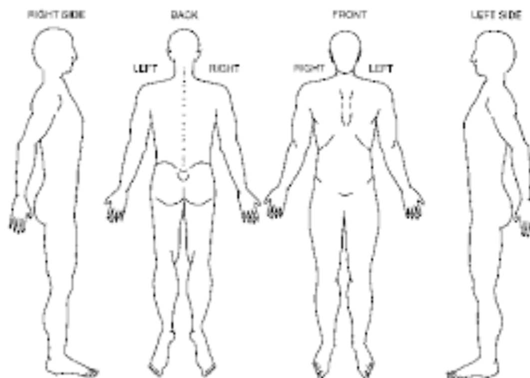
Current Medications: ____

Known Allergies: ____

What are your goals for receiving massage therapy? ____

If applicable, please Indicate area(s) of pain on the below diagram:



Please tell us about your pain. When did the pain begin? Is it getting worse? What aggravates it? Does it affect daily activities, work, or sleep?

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Have you ever had Massage Therapy before? ______

How did you hear about us? ______________________________________