Paul Perrotta & Associates

Massage Therapy Intake: Self-Pay

Last Name ______________________ First Name ______________________________
Street Address ______________________________ City __________ Zip __________
Phone: Home ______________ Work ______________ Cell ______________________
Occupation ______________ Date of Birth ____________ Age ______________
Sex: ☐ Male ☐ Female Email ______________________________________
How did you learn about us? ____

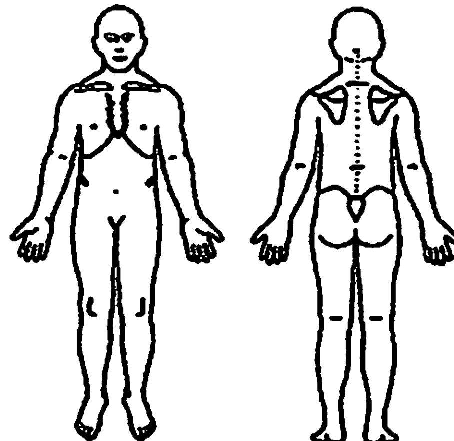
Have you ever experienced any of the following? Please use "C" for current, "P" for past, "S" for sometimes

__ HIV/AIDS
__ Allergies
__ Anemia
__ Athlete's Foot
__ Arthritis
__ Back Pain
__ Bone Fractures __ Eczema
__ Bursitis
__ Cancer
__ Chronic Fatigue __ Headaches
__ Circulatory Problems
__ Colitis __ Hemophilia
__ Jaw Clenching/Grinding
__ Constipation
__ Diarrhea
__ Diabetes
__ Digestive Problems
__ Disc Problems
__ Diverticulitis
__ Epilepsy/Seizures
__ Fibromyalgia
__ Heart Attack/Ailments
__ Herpes
__ High Blood Pressure
__ Low Blood Pressure
__ Insomnia
__ Excess Stress
__ Migraines
__ Muscle Spasms __ Tendonitis
__ Numbness
__ Phlebitis
__ Psoriasis
__ Rashes
__ Ringworm
__ Sciatica
__ Stiff Joints
__ Skin Allergies
__ Sprains/ Strains
__ Stroke
__ Swollen Feet/Legs
__ Tingling
__ Tumors
__ Varicose Veins
__ Whiplash
__ Other ____________

For women only: __ Pregnant __ Excessive Bleeding __ Menstrual Cramps
__ Trying to become Pregnant __ Amenorrhea __ PMS

Accidents, Injuries or Surgeries:
Please Specify ______________________________________ Date: ______________
Are you currently receiving medical or chiropractic care? ☐ Yes ☐ No
If yes, please explain ____
Are you currently taking any medications (prescription, over-the-counter or supplements)? ☐ Yes ☐ No
If yes, please explain ____
Why have you come for massage? ______________________________________
Have you received massage before? ☐ Yes ☐ No

Please circle areas of pain/stress/tension
"X" areas you do not wish to be touched; genitals are never touched.



Please read and sign the following:
I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will notify *Paul Perrotta & Associates* and/or treating LMP of any changes in my physical condition prior to massage. I am also aware that payment is due on the date of service.
A missed appointment or cancellation with less than 24 hours notice will be charged $65.00

______________________ ______________
Signature **Date**

11/09