KATIE TANDON, LMT

MASSAGE INTAKE FORM

Today's Date: _____

Patient Name: Last _____ First _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ -_____ Cell phone: (_____) _____-_____

Date of Birth: ____/____/____ Age: _____ Sex: (M or F)

E-mail address: _____

Who may we thank for referring you? _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: (_____) _____ - _____ Work phone: (_____) _____ -_____

Primary Care Physician: _____Phone_____

Medical Diagnosis –if any, list all_____

_____

Medications – if any, list all_____

_____

Aches or Pains - Chronic_____

Acute_____

Reason for seeking massage therapy_____

_____

I certify that all information stated on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date

OFFICE USE ONLY _____

DX:

Notes: