



### New Patient Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*First MI Last*

Address: \_\_\_\_\_  
*City State Zip*

Email: \_\_\_\_\_  check to approve communication via email

Phone: *H*(\_\_\_\_\_) \_\_\_\_\_ *W*(\_\_\_\_\_) \_\_\_\_\_ *C*(\_\_\_\_\_) \_\_\_\_\_

Sex: Female Male Marital Status: Single Married Other

Employer/School: \_\_\_\_\_ Full Time Part Time

Address: \_\_\_\_\_  
*City State Zip*

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

### Insurance Information

Company: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Are you the insured? Yes No

If you are not the insured, please provide the following information:

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
*City State Zip*

Employer/School: \_\_\_\_\_ Full Time Part Time

Address: \_\_\_\_\_  
*City State Zip*

### Massage History Information

Have you received an injury treatment massage before: Yes No

Depth of massage pressure preferred: Light Moderate Firm Deep

Do you have difficulty lying on your: Back Stomach Right Side Left Side

What are your expectations from today's massage: \_\_\_\_\_

### Medical History

Are you currently under the care of a health practitioner: Y N

If so, please explain: \_\_\_\_\_

Please list any over the counter or prescription medications you've taken today:

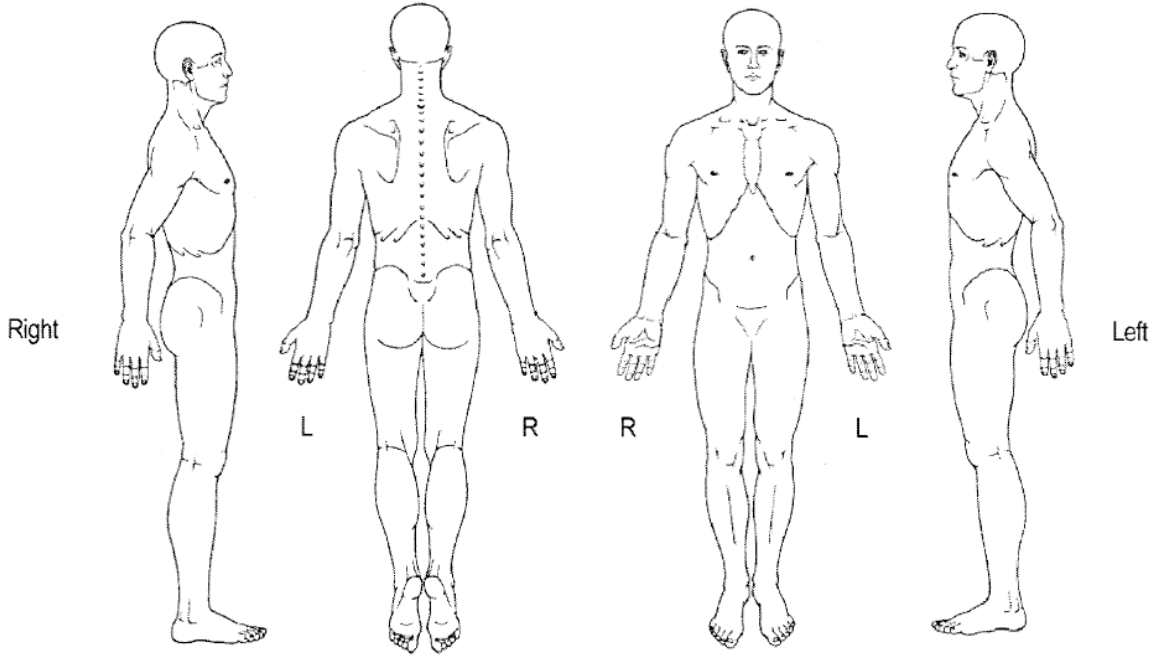
\_\_\_\_\_  
Please list history of heart conditions, including heart disease/congestive failure, low/high blood pressure, history of stroke, etc: \_\_\_\_\_

Have you been hospitalized or had surgery within the past 2 years:

\_\_\_\_\_  
Please list any recent injury or serious illness: \_\_\_\_\_

**Moon Rock Massage**  
1820 12th Ave., Seattle, WA 98122

Please indicate on the diagrams the area(s) where you are experiencing muscle and/or bodily discomfort and/or pain:



Which areas require extra focus? \_\_\_\_\_

Which areas would you like avoided? \_\_\_\_\_

**Thank you for taking the time to complete this information.**

**Patient's or Authorized Individual's Signature:**

- I authorize the release of any medical records or other information necessary to process this claim
- I authorize payment of medical benefits to Sarah Moon and/or Rebecca O'Connor
- I understand that my insurance may deny payment based on non-covered services or medical necessity. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within 30 days of invoice. Payment plans are available.
- My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Signed \_\_\_\_\_ Date \_\_\_\_\_