Holland Health Client Intake Form

In order to provide you with the safest and most effective treatment, we request that you fill in the form below. This information will be kept completely confidential and will be used only by our professional Holland Health staff to provide you with the best service.

Today's Date					
PATIENT INFORMATION					
Full Legal Name (First) (Middle) (Last)				Other name used (Nickname)	
Address		Apt. No.	City	State	Zip
Home-Phone	Email		Work Phone	Cell Phone	
Date of Birth	O Male O Female	Language	Race	How did you hear about Holland Health?	
List anyone you authorize this office to share your medical information with (name and relationship to you)					
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail				Ok to leave message on answering machine/voicemail? Yes___ No___	
EMERGENCY INFORMATION					
Emergency Contact:	Relationship	Contact Phone #	Cell or Work Phone #'s		
INSURANCE INFORMATION					
Primary Health Care Provider	Group #	Phone #	Policy Holder's Name/Parent's Name (if patient a child)		D.O.B.

(1) Have you ever received a professional massage? ☐ yes ☐ no Date of last massage? _____

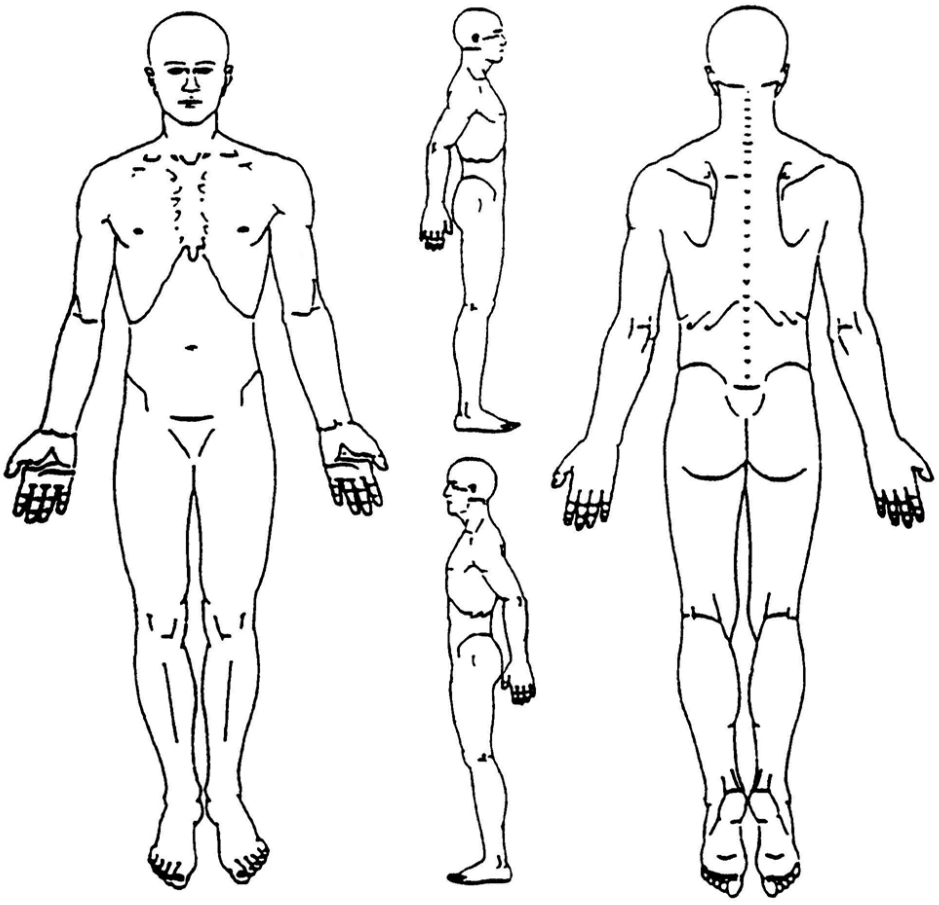
(2) How often do you visit a spa? ☐ Weekly ☐ Monthly ☐ Yearly ☐ First Time

What treatment (s) received? _____

(3) Type of Massage received: ☐ Swedish/Relaxing ☐ Deep Tissue ☐ Sports Specific ☐ Other

If other please describe: _____

(4) Prioritize the areas of the body you would prefer to be massaged or areas that need special attention. Please label the diagram below with numbers starting with 1 as the most important area.



(5) Are there any areas of your body that you prefer not to be massaged? _____

_____

_____

(6) What are your goals / expectations for this therapy session? _____

_____

(7) Have you ever had a reaction to an oil, cream or products application? ☐ yes ☐ no

If yes please explain _____

(8) Do you have any skin/body concerns or questions? ☐ yes ☐ no

If yes please explain _____