GOT QUALITY
MASSAGE LLC

Harbor Centers
98-027 Hekaha St. Bldg 3 Suite 21 Aiea, 96701

ReHab of the Pacific
226 Kuakini St. Honolulu, 96817

Interstate Building
1314 King St. suite 1551 Honolulu, 96814

Phone : 808-722-5182 * Fax: 808-595-0509 * Email: gotqualitymassage@icloud.com

CLIENT IN-TAKE FORM

NAME_____PHONE_____

ADDRESS_____CITY_____ ZIP_____

DATE OF BIRTH_____M____F____EMPLOYER_____

REFERRED BY_____Email_____Claim #_____

PREGNANT? Y____N____ CONTACTS? Y____ N____ HAVE YOU RECEIVED MASSAGE THERAPY? Y____N____

TYPE OF MASSAGE EXPERIENCE: SWEDISH____ DEEP TISSUE____ OTHER_____

ARE YOU UNDER THE CARE OF A PHYSICIAN AND/OR TAKING MEDICATIONS Y____N____

PLEASE SPECIFY_____

DO YOU HAVE A HISTOR OF THE FOLLOWING?

___accident	____sprains	____mastectomy
___neck pain	____seizures	____diabetes
___whiplash	____seizures	____anemia
___headaches	____abdominal pain	____low blood sugar
___shoulder pain	____scoliosis	____varicose veins
___upper back	____allergies	____high blood pressure
___mid back	____asthma	____stroke
___low back	____gout	____heart attack
___joint ache	____sciatica	____colitis
___decreased	____surgery	____hepatitis, A, B, C
Range of motion	____fibromyalgia	____HIV
___broken bones	____cancer	____carpal tunnel syndrome

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

___sunburn	____open cuts, bruises, burns
___inflammation	____irritated skin, rash
___severe pain	____numbness
___headache	____cold, flu

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS THERAPY SESSION? _____

_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

***I understand that this massage is not a replacement for medical care and that no diagnosis will be made.**
***I am responsible for paying for any massage therapy treatment that my insurance has not or will not pay.**
***I will inform "Got Quality Massage?" of any changes to the information I have provided above.**

Signature:_____Date:_____