



Spagnoli Massage & Wellness

Patient Intake Form

Personal Information

Name: _____

Date of Birth: _____

Address: _____

Email: _____

Phone Number: Cell: _____ Home: _____

Insurance: _____

Occupation: _____

Massage History and Preferences

Have you had a massage before? Yes No

Are there any areas you would like us to avoid?

Referred by: _____

What other treatment have you tried? _____

Pain and Symptoms

Main Complaint: _____

Did you have an accident/ surgery? Yes No If yes, please describe:

When/how did your pain start? _____

Level of pain (1-10): 1 2 3 4 5 6 7 8 9 10

What increases your pain? _____

What decreases your pain? _____

Please describe your pain: _____

Examples: Burning, Throbbing Spasm, Weak Pins / Needles, Numb, Sharp, Tender, Stabbing, Dull, Stinging, Shooting, Cramps, Aching, Tingling

Has your pain stopped you from participating in any activities? _____

Do you have head Aches: _____

Treatment Goals and Medical Information

What are your main goals of the treatment?

Are you pregnant? Yes No If yes, how far along?

List Medications: _____

Medical History: _____

List Allergies: _____

Additional Information: _____

Date: _____

Patient Signature: _____

