



# Standley Lake Massage Therapy, Inc.

8725 Wadsworth Blvd. Arvada, CO 80003  
303-425-7298

## SESSION INTAKE QUESTIONNAIRE

CHART NO.

### Please Print

NAME	DATE	
ADDRESS & CITY, STATE, ZIP  _____	BIRTH DATE	SEX ( M / F )
	OCCUPATION	
HOME PHONE # AND CELL PHONE # (INCLUDE AREA CODE)	HOW DID YOU HEAR ABOUT US?	
WORK PHONE # (INCLUDE AREA CODE)	MAY WE THANK SOMEONE FOR SENDING YOU IN? PLEASE PRINT NAME (REFERRALS RECEIVE A \$10 DISCOUNT)	
E-MAIL ADDRESS (NEVER SOLD, FOR SLMT, INC. USE ONLY)		
EMERGENCY CONTACT/RELATIONSHIP	EMERGENCY CONTACT PHONE #	
PRIMARY MEDICAL PRACTITIONER / PHONE NUMBER		

MAIN COMPLAINT (REASON FOR SEEKING MASSAGE THERAPY)

WHAT KINDS OF MEDICATIONS/NUTRITIONAL SUPPLEMENTS ARE YOU TAKING?

Please identify and describe any areas of discomfort by shading in problem areas on the diagram.

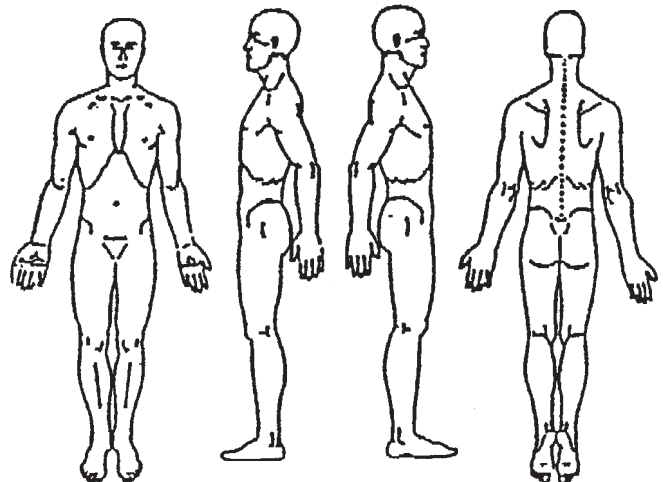
#### CIRCLE ONE

**Onset:** sudden, gradual      Date of onset \_\_\_\_\_

**Duration:** hours, days, weeks, months

**Frequency:** seldom, intermittent, frequent, constant

**Type:** sharp, dull, achy, tingly



FOR OFFICE USE ONLY:  CUSTOMER SATISFACTION CHECKUP      INITIALS \_\_\_\_\_ DATE \_\_\_\_\_

DO YOU HAVE PROBLEMS WITH: (PLEASE CHECK THOSE THAT APPLY)

L	R		L	R		
						WHIPLASH
		HANDS			PAIN DOWN LEG/SCIATICA	CIRCULATION/BRUISING
		ELBOWS			NUMBNESS/TINGLING IN EXTREMITIES	RHEUMATOID ARTHRITIS
		ARMS			LOW BACK PAIN	OSTEOARTHRITIS
		SHOULDER PAIN			NECK PAIN	ASTHMA/ALLERGIES
		FOOT PAIN			JAW PAIN/TMJ	ABDOMINAL PAIN
		ANKLES			HEADACHES	CONSTIPATION
		KNEES			SPRAINS/FRACTURES/DISLOCATIONS	MENSTRUAL PAIN

IS THERE ANY AREA THAT IS TENDER TO THE TOUCH OR ESPECIALLY SENSITIVE?

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CIRCLE IT:

ANGINA	FATIGUE/LOW ENERGY
COLD EXTREMITIES	PREGNANCY (IN THE LAST YEAR)
HARDENING OF THE ARTERIES	SURGERY (IN THE LAST YEAR)
HEPATITIS A B OR C (CIRCLE ONE)	ACCIDENTS OR FALLS (IN THE LAST YEAR)
HIGH OR LOW BLOOD PRESSURE	HOSPITALIZATIONS (IN THE LAST YEAR)
STROKE	RECURRENT INFECTION
THROMBOPHLEBITIS	HIV POSITIVE
USE OF ANTICOAGULANTS (SALICYLATE, HEPARIN, COUMADIN, ETC.)	EPILEPSY
VARICOSE VEINS	SKIN CONDITIONS OR OPEN WOUNDS
CANCER	HERPES
DIABETES	OSTEOPOROSIS
RECENT COLD/FLU (LAST FOUR WEEKS)	MEDICAL IMPLANTS

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOU BEFORE YOUR TREATMENT?

Thank you for completing this form. Please feel free to ask any questions. Now, or in the course of our work together, remember that I, as your massage therapist, am not a doctor and any suggestions made during your visit are recommendations, not prescriptions.

**Being under the effects of alcohol or certain medications during massage can put you at risk for injury.  
We reserve the right to refuse service.**

Client/Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)



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## **BROKEN APPOINTMENT POLICY**

It is Standley Lake Massage Therapy, Inc.'s responsibility to provide our clients with excellent therapeutic massage in a timely manner. Our business is based on service. As a business, we want to serve as many clients as possible each day; therefore, we reserve your appointment time to achieve that goal.

Your therapist is an employee paid by the session. Therefore, when you miss an appointment, it affects your therapist and our ability to fill our schedule.

Because of these two facts, we require notice for missed appointments.

We understand that people get sick, cars break down, etc., and will take that into account. For appointments that are forgotten or willfully missed, it is our policy to charge for those appointments.

No Show appointments or appointments cancelled with less than 3 hours notice will be charged \$35. Please make your check out to our office.

We also know that your time is valuable. By the same token, we will be responsible for our errors in scheduling or if a therapist is unable to keep your appointment with less than 3 hours notice. We will issue you a gift certificate for a massage in the value of \$35.

Thank you for your attention.

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Client Signature

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Therapist Signature