COLEEN SMALL, LMP
A pathway to healing
MA 00006402 • NPI 1720289234

INTAKE FORM – 1

Mailing Address
P.O. Box 30068, Seattle, WA 98103
Office Address
8401 5th Avenue NE, Seattle, WA 98115
(206) 420-7022

Name | Date of Birth

Address

City | State | Zip

Home Phone | Cell Phone | Work Phone

Email Address | Occupation

Emergency Contact | Phone

HEALTH HISTORY

Primary Care Provider | Phone

List all Surgeries / Injuries / Accidents / Major Illnesses (include year):

Please list current medical treatment/therapies you are receiving:

Please list current medications: | Reason:

Please list current diet restrictions: | Allergies:

Please list sleep difficulties:

Physical Activity: HEAVY MODERATE LIGHT What Kind?

How Often?

Please list in order of importance what conditions you would like help with

(1)

(2)

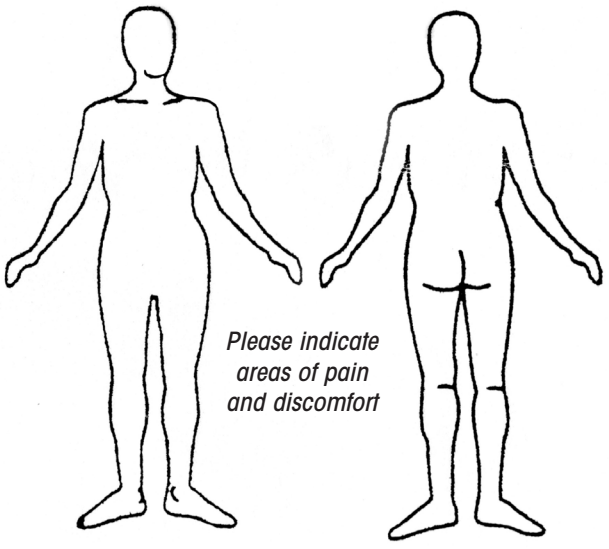
(3)

What results do you hope for?

(1)

(2)

(3)



Patient Name _____

INTAKE FORM – 2

Please indicate any current or past conditions in these boxes.

	NERVOUS SYSTEM
☐	Numbness / tingling in:
☐	Sciatica
☐	Pinched Nerve
☐	Muscular Dystrophy / MS
☐	Other:

	MUSCULOSKELETAL
☐	Low back / Hip / Leg pain
☐	Neck / Shoulder / Arm pain
☐	Sprain / Strains
☐	Spasms / Cramps
☐	Tendonitis / Bursitis
☐	Jaw Pain / TMJ
☐	Bone / Joint Disease
☐	Arthritis / Gout
☐	Osteoporosis / Scoliosis
☐	Lupus
☐	Other:

	SKIN
☐	Allergies
☐	Rashes
☐	Athletes foot / Warts
☐	Other:

	DIGESTIVE
☐	Ulcers
☐	Diverticulitis
☐	Irritable bowel syndorme
☐	Other:

	CIRCULATORY
☐	Heart condition
☐	Varicose veins / Phlebitis
☐	Blood clots / Thrombosis / Embolism
☐	High / Low blood pressure
☐	Lymphederma
☐	Other:

	RESPIRATORY
☐	Asthma / Difficulty breathing
☐	Allergies to:
☐	Sinus Problems
☐	Emphysema
☐	Other:

	REPRODUCTIVE
☐	Pregnant – stage:
☐	Ovarian / Menstrual problems
☐	Prostate condition
☐	Other:

	OTHER CONDITIONS
☐	Cancer / Tumors
☐	Diabetes
☐	Kidney / Bladder infections
☐	Chronic Fatigue / Fibromyalgia
☐	Chronic Pain in:
☐	Migraines / Frequent Headaches
☐	Inflammation / Swelling
☐	Communicable illness:
☐	Contact lenses HARD SOFT
☐	Other:

Please read and sign below – I am aware that this appointment time is being held expressly for me. I understand that Coleen Small, LMP requires a 48-hours notice to cancel or reschedule an appointment in order to avoid a $50.00 fee. If I miss an appointment the $50.00 fee will be charged directly to me. I also acknowledge that my insurance company is not responsible for any payment unless massage services have been rendered. I understand that payment for massage treatments are my personal financial responsibility and agree to pay for all services unless other arrangement has been made. I agree to the release of my medical information for insurance purposes and give Coleen Small, LMP permission to discuss such information with my healthcare providers to ensure safe and effective treatment. I assign medical benefits to be paid to Coleen Small, LMP.

SIGNATURE _____ DATE _____