Hawk Ridge Therapeutic and Medical Massage

1998 Hendersonville Rd Suite 13 Asheville, NC 28803 828-277-7672

Client Health History Intake

Date: _____

Name: _____ Birth Date: _____

first middle initial last

Address: _____

City & State: _____ Zip: _____

Home telephone: _____ Work telephone: _____

Mobile telephone: _____ Email: _____

Occupation: _____ Employer: _____

Insurance SS#: _____ *Your SS# is required only if we are billing insurance.)*
If we will be billing your insurance, please provide us with a copy of your insurance card -front & back. Also, please read our policy page for more information on insurance billing as we do not submit claims to all insurance carriers.

Personal Emergency Contact Information

Name: _____ Relationship to client: _____

Preferred Telephone: _____ Optional Telephone: _____

Primary Care Physician

Name of Doctor: _____ Phone: _____

City & State _____ Did your doctor refer you to us? Yes No

Please circle Yes or No to the following lifestyle questions:

Y N Do you exercise regularly?

Y N Do you sleep well for 7-9 hours each night? If not, why?

Y N Do you experience chronic unresolved stress in your life?

Y N Do you perform any repetitive movement in your work, sports or hobby?

Y N Do you sit for long hours at a workstation, computer or driving?

Y N Do you smoke or use tobacco products? Describe:

Y N Do you drink coffee, tea or sodas? Describe:

How did you hear about Hawk Ridge Therapeutic? _____