Confidential Health Intake Form

Name _____ Date of Birth _____

Street Address _____ City_____ State_____ Zip_____

Work Phone _____ Home phone_____Cell Phone/pager_____

Email address:_____ Emergency Contact/info_____

Employer/Occupation _____

Referring Physician:_____ Primary Care Physician:_____

Was Injury a result of an accident?_____ If yes: Job related_____ Auto _____ Other_____

Date of Injury or onset: _____

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___varicose veins
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___ depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems

Have you ever received massage therapy before? ____yes ____no Frequency:_____

Hearing abilities(communication is helpful during session):_____

Women only: ___Pregnant___ Painful menstruation___ endometriosis

Men only: ___Prostate problems

List all medications/herbs/vitamins and dosage: _____

_____

List physical activities you participate in regularly_____

What movements or activities are limited? _____

Describe the events of the injury or accident: _____

_____

List previous major injuries/broken bones/surgeries: _____

_____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

_____

Medical History and Information

What seems to help the most? _____

What seems to aggravate the condition the most?_____

What is your main activity at work? On phone _____ Sitting_____ Computer work_____

Driving car_____ Walking_____ Other _____

What do you do to relieve stress?_____

What do you want to get out of you session (s)?_____

Therapist Comments_____

_____

_____

It is my choice to receive massage therapy and I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in termination of the session, and I will be responsible for payment of the scheduled session.

Signature _____ Date _____