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/Health History and Information
Check any or all that apply to your past or present health:
Have you had a fever in the last **48 hours**?_______ yes _______ No
In the last 6-8 weeks:
Have you had any recent surgeries? ______yes ______No- if yes: date:________
Have you had any recent injections, infusions or other medical procedures?(this would include, vaccinations, botox, chemotherapy, steroids etc)
____yes_____ No- if yes: date:____________
If any of the above occurred in the last 6-8 weeks, we ask that you reschedule to another time. Call/text 804-439-6813 or email melissa@theohanacenter.com
If No, continue health intake questions.

Health History continued
___ 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):____

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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)?

____

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Therapist
notes/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 ___________________________________