Confidential Health Intake Form

Name _____ Date of Birth _____

Street Address _____ City_____ State_____ Zip_____

E-mail _____ Work Phone _____ Home Phone _____

Cell phone_____ Occupation: _____

Emergency Contact/Phone Number _____

Referred by: _____ Have you ever received a massage?_____

Medical History and Information

Reason for your visit:

_____

Please state any recent or past injuries or medical treatments:

_____

_____

Are you currently under the care of a health professional? Yes: _____ No: _____

Have you ever had hives/skin rashes/dermatitis? Yes: _____ No: _____

If yes please explain: _____

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

Women only: ___Pregnant(MUST be over 14 weeks) ___ Painful menstruation___ endometriosis

List all current medications/herbs/vitamins and dosage:_____

_____

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

_____

I am responsible for all charges for all services provided. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee.

Signature _____ Date _____