

# Health Intake Form

## Contact Information

Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Massage Information

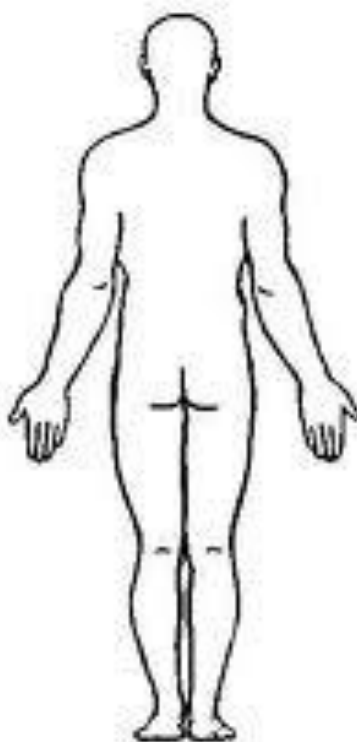
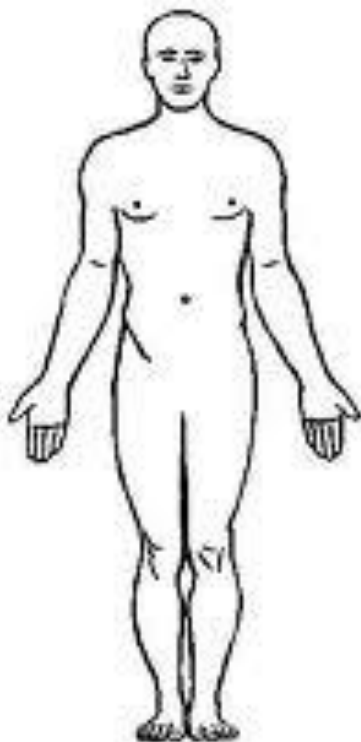
Have you ever received professional massage/bodywork before? Yes / No

What goals/expected outcomes for receiving massage/bodywork?

Occupation/Typical activities:

Are you wearing- Contacts: Yes / No Dentures: Yes / No Hairpiece: Yes / No

Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:



**P= Pain, ache, tenderness**

**S= Stiffness in the joint or muscle**

Rate Pain from 0-10, with 10 being "worst pain imaginable"

0-1-2-3-4-5-6-7-8-9-10

Rate function from 0-10, with 10 being "not able to do anything"

0-1-2-3-4-5-6-7-8-9-10

## Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

*Please, circle any of the following health conditions that you have or had in the past*

Muscle/Joint pain	Dizziness/ Ringing in the ears
Muscle/Joint stiffness	Digestive conditions (Crohn's, IBS)
Numbness/Tingling	Gas/bloating/constipation
Swelling	Kidney disease/infection
Bruise Easily	Arthritis (rheumatoid, osteoarthritis)
Sensitivity to touch/pressure	Osteoporosis, degenerative spine/disk
High/Low blood pressure	Scoliosis
Stroke, Heart attack	Broken Bones
Varicose Veins	Allergies
Shortness of breath, asthma	Diabetes
Cancer	Endocrine/thyroid conditions
Neurological (MS, Parkinson's, chronic pain)	Depression, anxiety
Epilepsy, seizures	Headaches/Migraines
Memory loss, confusion, easily overwhelmed	Pregnancy: Current / Past

List Medications:

## Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_