CONFIDENTIAL HEALTH INTAKE FORM

Contact Information:

Name _____ Date of Birth _____

Street Address/Apt Number _____

City_____ State_____ Zip_____ Contact Phone Number_____

Emergency Contact _____

Occupation/employer _____

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

Women only: ___Pregnant ___ Painful menstruation ___ endometriosis

Men only: ___Prostrate 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/surgeries: _____

_____

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

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_____

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)?_____

Practitioner Comments_____

_____

_____

Informed Consent and Acknowledgements:

_____I understand that the massage, bodywork, stretching and yoga therapies I receive is provided for the basic purpose of encouraging the body to maintain balance, plus providing relaxation and relief of tension in the soft tissues. If I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure, technique and/or strokes may be adjusted to my level of comfort.

_____I understand that massage and wellness practitioners do not diagnose illness, disease, or other physical or mental disorders; massage and wellness practitioners do not prescribe medical treatments or pharmaceuticals; and I understand that massage, bodywork, stretching and yoga therapies are not a substitution for a medical examination or diagnosis. The massage and wellness practitioner may recommend that I see a physician for any physical or mental issue that I might have, and it is my responsibility to address that issue. I have stated all my known medical conditions and I will keep my practitioner informed of any changes. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

_____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 agree that I am responsible to pay for all charges for all services provided at the time of each session.

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

Signature _____ Date _____