PERSONAL HEALTH INTAKE FORM

Full Name:____

Address:______________________________Apt:_________

City, State, Zip:___________________________________

Phone: (____)___________________________ Cell? Y N

Email: ________________________________

Occupation:____________________________

Please list all over-the-counter and prescription medications:

____

Please list all accidents, injuries and surgeries that have an effect on your daily living and their approximate dates:

____

Please check mark any current conditions that apply to you:

____ Allergies: ____ mold ____ pollen ____ dust ____ dander ________________ other

____ Arthritis: ____ osteo ____ rheumatoid ____ stiffness in joints?

____ Athlete's foot

____ Back pain: ____ upper ____ lower

____ Blood clots: _________ where? ____ Deep Vein Thrombosis (DVT)?

____ Blood pressure: ____ high ____ low ____ taking medication?

____ Cancer: ______________________ type?____ in remission ____ chemo
____ radiation ____ surgery ____ lymphedema ____ tumor

____ Carpal Tunnel Syndrome: ____ pain in arm / wrist ____ tingling / numbness
____ pain at elbow / up to shoulder

____ Cold / Congestion / Fever / Flu: ____ sniffles? ____ fever? ____ sinus congestion

____ Constipation / Digestive discomfort: ____ currently experiencing?

____ Contagious disease: ____ tuberculosis ____ scabies ____ impetigo
____ ringworm _____ cellulitis_____________________other

____ Diabetes: ____ Type I ____ Type II ____ insulin dependent ____ diet controlled

____ Fatigue: ____ trouble sleeping? ____ lethargic? ____ constant weariness?

____ Headaches: ____ migraine? _______________________ where does it start?
____ one sided? ______how often? ___________________ duration?

____ Heart: ____ pacemaker ____surgery_________________________________other

____ Hepatitis: ____ A,B,C,D,E,F____Treated?

____ HIV/ AIDS: ________________________

____ Infection: ______________________________where? _____ taking medication?

____ Inflammation: ____ "Frozen Shoulder" ____ Bursitis ____ Myositis
_________________________________other

____ Lupus: ____Remission? Y N

____ Muscle spasm: ____ due to singular event ____ recurring ____ are you a runner?
___________________________ athlete (sport)?

____ Neck / spinal injury or pain: _____ whiplash ______________________ when?
_____ "pinched nerve" _____ low range of motion
_________ bulge or herniation?

____ Pregnancy: ____ 1st trimester ____ 2nd trimester ____ 3rd trimester
________________________ due date?
____ Sciatica: ____ due to herniated disc ____ which vertebrae? ____ do you smoke?
____ quit smoking?
____ Scoliosis: ____ fused vertebrae ____ corrective surgery ____ functional with no surgery
____ Seizure: ____ epilepsy ____ taking medication? _________________________other
____ Skin: ____ acne ____ psoriasis ____ eczema ____ cellulitis ____ rash
____ rosacea ____other
____ Stroke: ____TIA ____ Aneurysm
____ Vertebral discs: ____ herniated ____ ruptured ____ vertebrae fused

What are your goals for your visit today? Long term goals?
____
____

Preferences? (i.e.- quiet session, coconut oil vs. massage cream, essential oils, ticklish at the knees, etc.)
____

How long ago was your last massage?____

Do you prefer LIGHT MODERATE DEEP pressure?

Client Waiver form
Please take a moment to read and agree to the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.
- I have read the statement above and agree to all the policies

____ ______________________________
Client Signature Date