Confidential Health Intake Form

Name_____________________________________ Date of Birth________________________

Address_____________________________ City________________ State_______ Zip________

Home Phone_______________________ Cell Phone_________________________

Emergency Contact_____________________________________

Emergency Contact Phone_____________________

Email____

Medical History and Information

Check all that apply to your present health:

___Headaches ___Chronic Pain ___Varicose Veins

___Contact Lenses ___Muscle/Joint Pain ___Blood Clots

___Sinus Problems ___Numbness/Tingling ___High/Low Blood Pressure

___Jaw Pain ___Sprains/Strains ___Diabetes

___Fatigue ___Scoliosis ___Cancer/Tumors

___Depression ___Arthritis ___Infectious Disease

___Sleep Difficulties ___Tendonitis ___Skin Problems

Women Only: ___Pregnant

Men Only: ___Prostate Problems

List all medications and dosages: ____

What is your goal for today's session: ____

List physical activities you participate in regularly: ____

List previous major injuries/surgeries: ____

What is your main activity at work? On Phone_____ Sitting_____ Computer Work_____ Standing_____

Driving Car_____ Walking_____ Other____

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.

Signature____ Date________________________