Confidential SELF Health Intake Form

Name _____

Street Address _____

City_____ State_____ Zip_____

Date of Birth _____

Work Phone _____ Home phone_____

Cell Phone/pager_____Email: Address_____

Emergency Contact _____Telephone_____

We truly value and appreciate your trust in us and, accordingly, ask you to read and acknowledge your understanding of the following:
If you have any questions or concerns or require clarification, please ask before signing.

Informed Consent

I acknowledge that the information provided on this health intake form is accurate to the best of my knowledge. I understand that the services, treatments, or recommendations I receive are to support my overall well-being and do not replace medical diagnosis or treatment from a healthcare professional.
I understand that the therapies may involve touching and palpating areas of my body. If I feel uncomfortable, I will inform the therapist immediately before or during the session about any areas of concern.
I consent to collecting, using, and disclosing my personal health information as necessary for providing care as per privacy regulations.
You can ask questions at any time and withdraw your consent to treatment at any point. Your understanding and comfort are our top priorities.
I understand that the therapist may elect to end the session at any time if, in their opinion, it is unsafe or beyond the scope of practice to continue.
Your participation in any recommended therapies is entirely voluntary, and we respect your autonomy in making this decision. You accept full responsibility for any outcomes, and we are here to support you every step of the way.
We may require payment in advance for services.
We operate a 24-hour cancellation policy, and fees for the booked service are due and payable.
Where a third party provides diagnostics, these will be offered subject to the terms and conditions provided when ordering.

Signature _____
Date _____/_____/_____

Medical History and Information

Check any or all that apply to your present health. Give a brief description:

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

History of Childhood Diseases (list only those you feel relevant)

_____
_____
_____
_____

Women only:

Pregnant_____ Painful menstruation_____ endometriosis_____

Men only:

Prostrate problems_____Erectile Dysfunction_____

List all medications/herbs/vitamins and dosage:

_____
_____
_____
_____

List physical activities you participate in
regularly_____

Describe the events of any relevant injury or accident:

_____
_____
_____

List previous major injuries/surgeries (10 Years)

_____
_____
_____

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

_____
_____
_____

When did you last receive treatment?

_____

_____

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 _____

How much fluid do you drink?

Water_____Coffee_____Soda_____

Alcohol_____(units per day, one glass of wine equals one unit)

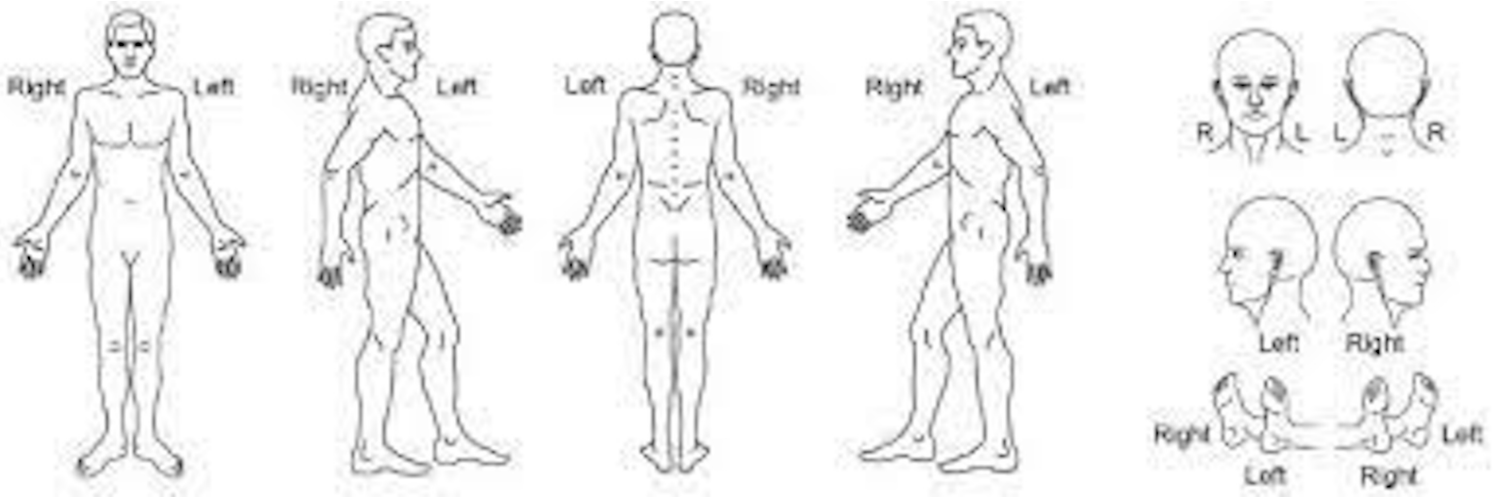
Do you smoke? Yes_____No_____How many per day_____

What do you do to relieve stress?_____

Current Weight:_____

Current Height:_____

Please indicate by shading or marking any areas of pain consistently felt in any body part in the last seven days. Where such pain reoccurs, please indicate any noticeable patterns or frequencies.



Permission to Keep Credit Card on File:

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____/CVV_____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize you to charge my credit card above for agreed-upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature Date