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___________________________

It is my choice to receive massage therapy and or any other holistic therapy and I give consent to receive treatment. I understand that therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage and any other therapy is not a substitute for medical examination and/or diagnosis.
If I am signing on behalf of a person in my charge I acknowledge that I have full authorization to do.
I affirm that I have stated all known medical conditions and shall take it upon myself to keep my Therapist updated on my physical/mental health.
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 other therapies and give my consent to receive it.
I will consult my practitioner with any questions or concerns immediately either prior to or during the session.
Please be aware that the therapist may end the session at any time if, in the opinion of the therapist, the client engages any form of unacceptable behavior either verbal or physical. Payment for the full session will be payable.
Any suggestions made by the therapist during or after the session do not constitute a diagnosis and recommendations made are accepted at the clients own risk.
I have stated all medical conditions on the sheet attached that I am aware of and will keep my practitioner informed of any changes.
I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.

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?____________________________________