



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 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? _____

List any Medical Implants: Including dental

Treatment for Cancer: Radiation Chemotherapy Other

If yes when and for how long

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 cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____ CVS _____
Expiration Date (mm/yy):	_____
Cardholder ZIP Code (from credit card billing address):	_____

I, _____, authorize HHSWF OR AMHHSLLP 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