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: and rate for Severity on scale of 1-9 1 being low 9 being high.

Separation anxiety, panic, other forms of anxiety
Behavioral regression: Kids suddenly acting much younger than they should for their age, such as reverting to baby talk.
Emotional lability: These children can be severely depressed, even suicidal
Irritability, aggression and /or severely oppositional behaviors
Deterioration in school performance: Sudden decline in math and reading competence, memory and concentration; increase in hyperactivity
Motor or sensory abnormalities: Handwriting and drawing deteriorates dramatically (also linked to regression), and they may be distressed by noise or light
Somatic symptoms: These include sleep disturbances, bedwetting and other changes in urinary frequency or intensity
sinus problems

Constant Throat Infections
jaw pain/teeth grinding
Constant Ear Infections
Upset Stomach
Hallucinations Auditory or Visual
Hand Wringing or Repetitive Behavior
Tourette syndrome
Other Symptoms
fatigue
scoliosis
cancer/tumors
depression
arthritis

infectious disease
sleep difficulties
tendonitis
skin problems
Scarlet Fever
Tick Bites
Impetigo

Date of First Antibiotic Treatments _____

Positive Diagnosis of Strep Yes/No

Strep Type (please circle) A,,B, C G

Name of Antibiotics
Used_____
_____
_____

Dosage (if known)_____

Duration (if known) _____

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

List all medications/herbs/vitamins and dosage:

Describe the events of any relevant injury or accident:

List previous major injuries/surgeries (10 Years)

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

When did they last receive treatment?

What seems to help the most?

What seems to aggravate the condition the most?

_____

Birth History:

C Section

Natural (Short Labor)
Natural (Long Labor)

Induced

Vaccination History: Tick Box for Yes Leave Blank for No

Chickenpox	Varicella	
Diphtheria	DTaP*	
Hib	Hib	
Hepatitis A	HepA	
Hepatitis B	HepB	
Influenza (Flu)	Flu vaccine	
Measles	MMR**.	

Mumps	MMR**	
Pertussis	DTaP*	
Polio	IPV	
Pneumococcal	PCV13	
Rotavirus	RV	
Rubella	MMR**	
Tetanus	DTaP*	

Birth Mother History

Any relevant history of mental illness anxiety, medication, trauma

_____
_____
_____
_____
_____
_____

Family History:

Any relevant history of mental illness, anxiety, medication, trauma

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Insurance Carrier:

Please be aware that we do not process insurance claims but maybe able to issue invoices that are covered by your health care provider or eligible under FSA or HSA rules: Please check with your Insurance PRIOR to committing to obtaining services:

Informed Consent: Initial

I understand and fully accept that such consultants and services that I or my family may receive do not constitute MEDICAL advice _____

Signature and Consent/Permission for Services

Before making the decision regarding enrollment in this service offering you should have:

- Discussed this study with an investigator,
- Reviewed the information in this form, and
- Had the opportunity to ask any questions you may have.

Your signature below means that you have received this information, have asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference.

Participant: By signing this consent form, you indicate that you are voluntarily choosing to take part in this service.

Participant's Legally Authorized Representative: By signing below, you indicate that you give permission for the participant to receive services.

(Signature of Participant's Legally Authorized Representative is required for people unable to give consent for themselves.)

_____Date_____

Description of the Legally Authorized Representative's Authority to Act for Participant:

[Description of the authority]

_____

Person Explaining the Services : Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the Services.

_____Date_____

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

I,_____, authorize_____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