Health Intake Form

Personal Information

Name ____ Date of Birth ____________________
Address ______________________________ Emergency Contact ___________________________
______________________________ Contact's Phone ______________________________
Email __________________________________ Referred by ______________________________
Phone (primary) ______________________ Occupation ________________________________
(secondary) ______________________ Gender __________________________________
How did you hear about us? ____
Would you like to receive newsletters and/or emails with special offerings? We will NOT share your information.
YES ______NO______

Health History

Are you pregnant/ breast-feeding? YES _____ NO______ Do you wear contact lenses? YES ____ NO_____
Do you have any metal implants (including braces?) YES _____ NO______
Please list all serious injury: ____
____
____
Please list any surgeries: ____
____
____
Please list all allergies: ____
____
Please list any medications: ____
____

Please check any conditions, past or current, which apply to you:

___ Fibromyalgia	___ Osteoporosis	___ Skeletal Injury/ Dysfunction
___ Heart Disease	___ Arthritis	___ Diabetes
___ Disc Herniation	___ High/Low BP	___ Cancer/ Tumor
___ Digestive Conditions	___ Contagious Diseases	___ Open Cuts/ Sores
___ Swelling/Clotting Problems	___ Joint Replacement	___ Muscular Injuries
___ Varicose Veins	___ Neurological Problems	___ Stroke

Other ____
____
Is there any traumatic event or experience that you would like your therapist to know about?
____
____

Consent

1. I affirm that I have stated all my known medical conditions and have answered all questions honestly. I understand that service is provided for the purpose of relaxation/relief of muscular tension and is NOT a substitute for medical examination, treatment, or diagnosis. For these concerns, I will seek the advice of a medical professional.
2. All services are non-sexual. Both the therapist and I have the right, at any time, to terminate a session.
3. I understand that a 24 hour notice is required for all reschedules and cancellations.
4. Missed appointments will be charged up to the full charge of the scheduled treatment.
5. I accept payment for missed appointments if I fail to provide the required notice.

SIGNATURE ____ **DATE** ____________________