Wellness Therapies

MASSAGE

Health Intake Form

Please complete the following questions carefully. All data is confidential to ensure your privacy.

Name:____

Address:____

City:_________________________________ State:_________________________ Zip:_____________

Occupation:__________________________________ Employer:____

Phone # ____Send text reminders to this phone? ________

Email Address: ____May we contact you at this email address? _____

Emergency Contact_______________________________________ Phone #_________________________________

Birthdate________________________________ Height ___________ Weight __________ Female____ Male____

Marital Status__________________ # of children___________

How did you hear about us?____

Medical Care: Date of most recent visit to a Primary Care Physician (PCP) _________________________________

Are you currently receiving healthcare by MD/ND/Homeopath doctor(s) __________________________________

How would you rate your general health? Excellent______ Good_______ Fair_______ Poor________

Have you had a professional massage before? Yes __________ date of last treatment_______ No_______

Please list any allergies or hypersensitiveness

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____
____
____
____

Reason for initial visit:

____
____
____
____
____

Please list current medications & conditions being treated

____
____
____
____
____

Any major accidents or injuries? Include dates

____
____
____
____
____

Continue to page 2

Antidote Wellness Therapies

MASSAGE

Health Intake Form

HEAD NECK

- ○ Headaches / migraines
- ○ Vertigo / dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Numbness / tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Phlebitis / varicose veins
- ○ Pacemaker
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV / AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Unexplained weight loss
- ○ Digestive conditions
- ○ Fibromyalgia
- ○ Chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Other conditions ______________________________

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____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature______________________________ **Date**______________________________

Parental Consent to treat minor: **Minor Name Please Print:**______________________________

Parent or Guardian Signature ______________________________