Caring Hands Massage Therapy, llc

CONFIDENTIAL HEALTH INTAKE FORM

PLEASE FILL OUT ALL APPLICABLE INFORMATION

PRINT ALL INFORMATION CLEARLY

Personal Information:

Name: _____ Month/Year of Birth: _____

Address: _____ City: _____ State: ____ ZIP: _____

Telephone: Home (_____) _____ - _____ Cell: (_____) _____ - _____ **Circle best number to reach you: Home / Cell**

Email: _____@_____ Would you like to receive monthly newsletter? **Yes or No**

(Please Print)

Emergency contact: _____ Phone: (_____) _____ - _____

Your occupation:_____ How do you relieve stress and/or pain: _____

Primary care physician: _____ Chiropractor: _____

How did you hear about Caring Hands? _____ Were you referred? _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Medical History:

Have you ever received professional massage or bodywork before: Yes - No _____ How recently: _____

- Type of massage experienced (Swedish, deep tissue, hot stones etc.)_____
- What kind of pressure do you prefer? Circle one: **(light)** (medium) (firm)
- What are your massage/bodywork goals? (**Relaxation / Addressing an injury**)? _____
- Do you have tension or soreness in a specific area? _____
- Are you sensitive to touch or pressure in any area? _____

Are you currently taking any medications? Please circle: Yes / No

- **If Yes**, please list name and reason for medication(s): _____

Are you currently (or recently) in the care of a healthcare professional? Please circle: Yes / No

- **If Yes**, please list name(s) and reason /treatment: _____

Have you had any serious or chronic illness, operations or traumatic accidents? Please circle: **Yes / No**

- **If Yes**, please explain: _____

What is your activity level and what are the types of activities you engage in; **exercise, hobbies, etc.**?

Explain: _____

Please review this list and check those conditions that have affected your health, either now or in the past. Place a √ mark next to the condition:

[ ] Allergies	**[ ] Bruise easily**	**[ ] Pregnant – what month _____**
[ ] Headaches, migraines	**[ ] Fibromyalgia**	**[ ] Muscle Spasms - strain**
[ ] Diabetes – Type 1 or Type 2	**[ ] TMJ – jaw pain**	**[ ] Epilepsy or seizures**
[ ] High or Low blood pressure	**[ ] Cardiac or Circulatory problems**	**[ ] Heart attack - stroke**
[ ] Broken bones – fractures	**[ ] Sensitive to scent(s)**	**[ ] Artificial Joint Replacement**

[ ]Neck, shoulder, or arm pain or numbness or tingling in fingers **[ ]Low back, hip or leg pain or numbness**

[ ] Deep vein thrombosis – blood clots or varicose veins **[ ] Contagious skin condition – open sores or wounds**

[ ] Joint disorder(s) – rheumatoid arthritis – osteoarthritis – tendonitis – bursitis **[ ] Are you wearing contact lenses - dentures**

Office Policy:

Please read the Office Policy and initial indicating you were given a copy regarding Lateness, Payment, Gift Certificates, Cancellation and/or No-Show Receipt acknowledged _____ (initial)

One Email Text Phone

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any medical or mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to so. I also understand that any illicit or sexually suggestive remarks or advances made by me (client) will result in immediate termination of the session and I will be liable for payment of the schedules appointment.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____