

Confidential Health Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

DOB ____/____/____ Age _____ Marital Status ___M___S___D___W

Occupation _____ Employer _____

Name of Spouse or Partner _____

Nearest relative not living with you _____

Emergency Contact _____ Phone # _____

What do you do with the majority of your free time (hobbies, outside of work)?

Have you had any serious illness? If so please describe. _____

Please list any operations or traumatic accidents you have had within the past 5 years? _____

List any medications you are taking: _____

Do you regularly take vitamins or supplements? If so, please list: _____

Are you currently being treated by a physician, chiropractor or other health care professional? Y N
If so, please list their name and location: _____

Have you ever received a professional massage? Y N If so please list the therapists name _____

What is your main goal of this massage: _____

How did you find out about my services? _____

I understand that massage services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any massage is educational in nature and is intended to help you become more familiar and conscious of your own health status and is to be used at your own discretion. All information exchanged in massage sessions and/or on this intake form are confidential and will not be shared unless required by a referring doctor. I have provided all information on this form completely and correctly and I understand it is my responsibility to inform this office of any changes in my medical status.

Payment in full will be collected at the time of service.

Signature _____ Date _____