

# Confidential Intake Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
How would you like us to contact you? \_\_\_\_\_  
Status:  single  married  divorced  widowed  separated  
Living Situation:  alone  friend  partner  spouse  children  
How did you hear about us? \_\_\_\_\_  
Referred by: \_\_\_\_\_

## Medical/Emergency Contacts

Primary Physician: \_\_\_\_\_  
Phone no: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Phone no: \_\_\_\_\_

## Occupational Factors

What do you find yourself doing most during the day?  
(Ex. Sitting, standing, computer, driving, etc.) \_\_\_\_\_  
\_\_\_\_\_

## Exercise, Sports, Hobbies, Family

\_\_\_\_\_, \_\_\_\_\_ times per \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_ times per \_\_\_\_\_  
Children ages \_\_\_\_\_  
Other \_\_\_\_\_

## Medications/Vitamins/Herbals

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies: I am allergic to:

\_\_\_\_\_  
\_\_\_\_\_

## Massage Therapy History & Goals

Y  N I have had professional massage before.  
If yes, how long ago: \_\_\_\_\_  
For: \_\_\_\_\_  
Regular massage received:  Y  N  
If yes, how frequently: \_\_\_\_\_  
 Y  N I am here for relaxing massage.  
 Y  N I am here for relief from headaches.  
 Y  N I am here by Dr. referral for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
 Y  N I am here for the following: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Other Medical Information

Y  N Are you currently seeing other practitioners?  
If yes, who? MD ND DC DO PT LMP Counselor  
Nutritionist Personal Trainer Other: \_\_\_\_\_  
\_\_\_\_\_  
Hospitalizations/Surgeries within the last 10 years: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Conditions: Review of Systems

<u>Past</u>	<u>Current</u>		<u>Past</u>	<u>Current</u>		<u>Past</u>	<u>Current</u>	
<input type="radio"/>	<input type="radio"/>	fatigue	<input type="radio"/>	<input type="radio"/>	gas	<input type="radio"/>	<input type="radio"/>	swelling of ankles
<input type="radio"/>	<input type="radio"/>	weakness	<input type="radio"/>	<input type="radio"/>	constipation	<input type="radio"/>	<input type="radio"/>	other edema/swelling
<input type="radio"/>	<input type="radio"/>	dizziness	<input type="radio"/>	<input type="radio"/>	diarrhea	<input type="radio"/>	<input type="radio"/>	leg cramps
<input type="radio"/>	<input type="radio"/>	insomnia	<input type="radio"/>	<input type="radio"/>	urination problems	<input type="radio"/>	<input type="radio"/>	osteoporosis
<input type="radio"/>	<input type="radio"/>	hearing troubles	<input type="radio"/>	<input type="radio"/>	urinating at night	<input type="radio"/>	<input type="radio"/>	bone injuries
<input type="radio"/>	<input type="radio"/>	ringing in the ears	<input type="radio"/>	<input type="radio"/>	bladder infections	<input type="radio"/>	<input type="radio"/>	disk problems
<input type="radio"/>	<input type="radio"/>	nasal discharge	<input type="radio"/>	<input type="radio"/>	menstrual problems	<input type="radio"/>	<input type="radio"/>	arthritis
<input type="radio"/>	<input type="radio"/>	sinusitis	<input type="radio"/>	<input type="radio"/>	menopausal problems	<input type="radio"/>	<input type="radio"/>	diabetes
<input type="radio"/>	<input type="radio"/>	cough	<input type="radio"/>	<input type="radio"/>	varicose veins	<input type="radio"/>	<input type="radio"/>	weight problems
<input type="radio"/>	<input type="radio"/>	shortness of breath	<input type="radio"/>	<input type="radio"/>	change in hair	<input type="radio"/>	<input type="radio"/>	dental trouble
<input type="radio"/>	<input type="radio"/>	blackout/fainting	<input type="radio"/>	<input type="radio"/>	skin rash	<input type="radio"/>	<input type="radio"/>	chest pain
<input type="radio"/>	<input type="radio"/>	anemia	<input type="radio"/>	<input type="radio"/>	skin growth	<input type="radio"/>	<input type="radio"/>	heart palpitations
<input type="radio"/>	<input type="radio"/>	heartburn	<input type="radio"/>	<input type="radio"/>	numbness/tingling/ burning	<input type="radio"/>	<input type="radio"/>	high blood pressure
<input type="radio"/>	<input type="radio"/>	trouble swallowing	<input type="radio"/>	<input type="radio"/>	cold hands and feet	<input type="radio"/>	<input type="radio"/>	low blood pressure
<input type="radio"/>	<input type="radio"/>	abdominal pain	<input type="radio"/>	<input type="radio"/>				

Signature \_\_\_\_\_

Date \_\_\_\_\_