CONFIDENTIAL HEALTH HISTORY/MASSAGE INTAKE FORM

Welcome. I want your appointment to be as pleasant and comfortable as possible. If you have any questions, please let me know.

First Name:_____ M.I.____ Last Name:_____

Address:_____ City:_____ Zip:_____

Phone (Cell/work):_____ E-Mail:_____
Birth Date: _____/_____/_____ Occupation:_____
Emergency Contact: _____ Phone:_____ Relationship:_____

Do you wear contacts? _____ Dentures? _____ Hearing Aid? _____ Do you exercise? _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

When was your last massage? _____ How frequently do you get a massage? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago:_____

Do you have any chronic, ongoing pain that you deal with on a regular basis? Yes ____ No ____

Please explain: _____

Describe what activities cause this pain and/or make it worse:_____

Please list all current medications:_____

Do you have allergic reactions to any oils, lotions, or other substances applied to your skin? Yes __No___

If yes, please identify and explain _____

Check any or all that apply to your present health:

___Headaches	___Numbness/tingling	___Varicose veins
___Vision Problems	___Blood clots	___High/low blood pressure
___ Sinus Problems	___Scoliosis	___Muscle or joint pain where:_____
___Jaw pain/teeth grinding	___Arthritis	___ Tendonitis where:_____
___Fatigue	___Diabetes	___Cancer/tumors describe:_____
___Depression	___Lymphatic condition	___Infectious disease
___Sleep Difficulties	___Osteoporosis	___HIV/Aids

___Skin condition (location/infectious? For how long?)_____
Women: Pregnant? No ___ Yes ___ Due Date: _____Men: Prostate problems? No___ Yes ___

I have notified the massage therapist and Botha Chiropractic of my health conditions. I understand that it is my responsibility to make her aware of pain, discomfort, or concerns that arise during the massage session or afterwards. Receiving massage therapy is not contrary to my physician's recommendation, and I am aware that massage therapy does not cure disease, though it supports my health. I am also aware that it is beyond a massage therapist's scope of practice to diagnose or prescribe medication. **I also have not consumed drugs or intoxicating substances prior to my appointment.**

Reschedule / Cancellation Policy: _____(Initial)
24 hour notice is required when cancelling an appointment, except in cases of emergency, illness, or inclement weather. Reschedule and/or cancellation WITHOUT 24 HOUR NOTICE WILL RESULT IN A $40 CHARGE FOR YOUR SESSION as that time has been set aside specifically for you.

_____

Signature **Date**