Kneading Knots
MASSAGE THERAPY

CONFIDENTIAL HEALTH INTAKE FORM

All information is kept confidential and will become part of your personal file.in order to provide the best possible care and to insure optimum results from your sessions, the following information is essential and should be completed completely and accurately. If your intake is not completed accurately, thoroughly, and completely; we will not be able to perform your service.

Demographic Information

Please Print

Name:_____Date_____

Address:_____City_____State_____Zip_____

Phone:_____Cell:_____

Email:_____

Age:_____Occupation:_____

What are your primary actions at work? Walking_____ Standing_____ Lifting_____
Typing/Computer Other_____

Emergency Contact Information

Name:_____Relationship:_____

Phone:_____

Are you currently pregnant? No_____ Yes_____ If yes how many Weeks? _____
Are you currently under medical care (Doctor, Chiropractic, Holistic)? Yes____ No_____

Doctor's Name:_____Phone:_____

Please list the reason for your visit and your expectations from receiving this service today:

_____

_____

_____

VITAL HEALTH INFORMATION

Have you had surgery recently with 6 weeks or less?_____ DATE_____

List surgeries_____

List major illness or hospitalization (past 8 months)

_____

_____

Do you have any of the following conditions? Check all that apply:

(_) Headaches	(_) Chronic Pain	(_) Varicose Veins	(_) Muscle Pain
(_) Blood Clots	(_) Sinus	(_) Numbness/ tingling	(_) Arthritis
(_) Sciatica	(_) Joint Pain	(_) Diabetes	(_) Fatigue
(_) Depression	(_) Sleep Difficulties	(_) Scoliosis	(_) Tendonitis
(_) Upper Back Pain	(_) Mid Back Pain	(_) Low Back Pain	(_) Fever
(_) Cancer/ Tumors	(_) HIV / AIDS	(_) Infectious Disease	
(_) Jaw pain/ teeth grinding/ clenching/ TMJ			

Please elaborate on issues:_____

_____

_____

Prescription / Over the Counter Medications: _____

_____

Massage:

Have you had a massage before? Yes_____ No _____ Date of Last Massage_____

What physical movement limits you? _____

What movement aggravates your condition the most?_____

What seems to help?_____

PLEASE READ AND SIGN:

Please understand that due to answering questions we do not diagnose or prescribe but offer information only to help you to cooperate with your doctor in your mutual quest of building optimum health. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes in the future

Date:_____ Printed name:_____

Signature: _____