Equilibrium Breath & Bodywork

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Confidential Health Intake Form, pg.1

Name _____ Date of Birth _____

Street Address _____ City _____ State_____ Zip_____

Best phone # to reach you: _____ 2nd best: _____

Email address:_____ Employer/Occupation _____

Emergency Contact/info_____

Referring Physician:_____ Primary Care Physician:_____

Was the injury a result of an accident? _____ Date of Injury or onset: _____

Have you ever received massage therapy before? ____yes ____no Frequency:_____

Women only: ___Pregnant

List all medications/herbs/vitamins: _____

_____

List physical activities you participate in regularly_____

_____

Describe the events of the injury or accident (if applicable): _____

_____

_____

List previous major injuries/broken bones/surgeries: _____

_____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic):

_____

What seems to help the most? _____

What seems to aggravate the condition the most?_____

What is your main activity at work? _____

What do you do to relieve stress?_____

What result do you want out of your session (s)?_____

Do you have a particular short term health related goal that you are currently trying to reach?_____

_____

Long term goal? _____

_____

Check any or all that apply to your present health:

___ headaches
___ vision problems
___ sinus problems
___ jaw pain/teeth grinding
___scoliosis
___ depression
___ sleep difficulties
___ hearing loss

___ varicose veins
___muscle or joint pain
___numbness/tingling
___sprains/strains
___ low blood pressure
___infectious disease
___tendonitis

_____

___ asthma
___ allergies
___ celiac disease
___ digestive disorder or issue

_____

I am interested in only the minimal changes required to maintain or improve my health.
Yes ___ No ___

I am interested in taking health and performance to a higher level.
Yes ___ No ___

I wish to restore health and healing to my body.
Yes ___ No ___

___ high blood pressure*
___ weight loss resistant*
___ high triglycerides/cholesterol*
___ elevated glucose, insulin, leptin*
___heart disease
___type II diabetes
___ neurological disease
(specify:_____)
___ irritable bowel syndrome
___ hormone imbalance
(specify: _____)
___ skin conditions
___ stroke or blood clots
___arthritis
___ ADD/ADHD
___autism
___cancer/tumors
(specify: _____)
___ fatigue
(chronic? Y or N)
Other: _____
_____
_____

It is my choice to receive massage therapy and I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature _____ Date _____