Restored by Touch Confidential Health Intake Form

Name _____ Date of Birth _____ Age: _____ Height:_____ Weight:_____

Street Address _____ City_____ State_____ Zip_____

Work Phone _____ Home phone_____Cell Phone/pager_____

Email: _____ Circle your preferred method of contact that is listed above. Would you like to be on my email list for special offers: χ Yes χ No E-mail newsletters: χ Yes χ No

Employer _____ Occupation/Position _____

Emergency Contact: Name and Phone _____Relationship: _____

You were referred to me or found me by: _____

Check any or all that apply to your present or past:

___ headaches
___chronic pain
___varicose veins
___ neurological issues—FMS, MG, MS, other: _____
___muscle or joint pain or arthritis
___osteoporosis
___ sinus problems
___numbness/tingling
___high/low blood pressure
___ jaw pain/teeth grinding
___sprains/strains
___diabetes
___ fatigue
___ postural dev. (scoliosis, etc)
___cancer/tumors (? Family hx, breast ca)
___ depression
___ chicken pox /shingles
___infectious disease
___ sleep difficulties
___tendonitis
___ disk problems/pinched nerve
___ liver, kidney
___ phlebitis / blood clots
___ rods, plates, implants
___ cardiovascular / stroke
___ digestive
___ infection
___ skin /nail disorders (acne, fungus, etc)
___ bursitis
___ swelling / edema
___ prostrate issues (men only)
___ nothing above applied

Women only: Pregnant (see pregnancy form) ___ Painful menstruation ___ Endometriosis ___

List previous major injuries/surgeries and/or <u>any</u> medical conditions, accidents, and bone, joint or muscle problems not specified previously (use back of page if necessary): _____

_____

List <u>all</u> medications/herbs/vitamins and dosage: _____

_____

How much you drink in 24hr period: water _____ alcohol _____ caffeine_____

What is your main activity at work? On phone _____ Sitting_____ Computer work_____

Other _____

List regular non-work physical activities: exercise, hobbies, recreation, etc. _____

Location of any current pain _____ How long have you had this pain: _____ Type of pain:

__ Sharp __ Dull __ Throbbing __ Numbness __ Aching __ Shooting
__ Burning __ With Movement __ Tingling __ Cramping __ Stiffness __ Swelling

__ Other _____

What movements or activities are limited?

__ Work __ Sleep __ Recreation __ Daily routine __ Standing __ Sitting
__ Walking __ Bending __ Lying down

Other / details or clarifications:

_____

Describe the events of the injury or accident: _____

_____

What other treatments are you receiving and by whom—name, occupation, & diagnosis/ condition being treated (acupuncture, physical therapy, chiropractic, naturopathic, . . .): _____

_____

What seems to help the most? _____

What seems to aggravate the condition the most? _____

What do you do to relieve stress? _____

Have you ever received a professional massage? [ ] yes [ ] no

What do you want to get out of your massage session(s)? _____

- ✓ 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 understand the **importance of staying well hydrated** before and after massage therapy.
- ✓ I understand the importance of informing my practitioner of any **health changes** before receiving treatment—even a common cold or other minor condition.
- ✓ For my wellbeing and others, I will reschedule if I have any **airborne disease in a contagious stage** – ie cold or influenza.
- ✓ I understand massage therapy has the most benefit when combined with **self-care** such as affective stress management, exercise therapy, proper nutrition and hydration.
- ✓ I have stated all medical conditions that I am aware of and will **keep my practitioner informed** of any changes.
- ✓ I agree to provide **24-hour** cancellation notice **via cell phone call** (not email or text; they're unreliable for time sensitivity). If I fail to do so, I agree to pay the **full** appointment fee. (Please note insurance companies do not pay this; clients do.)
- ✓ I certify that my **health history and personal information is correct** to the best to my knowledge. I **will not hold my therapist responsible for any errors or omissions I may have made** in the completion of my intake forms.
- ✓ I understand massage therapy services are designed to be a health aid and are in **no way a substitute for a physician's care**. **Information** by the therapist is **educational in nature and is to be used at my own discretion**.

Print or Type name _____

Signature _____ Date _____

Practitioner Comments

_____

_____

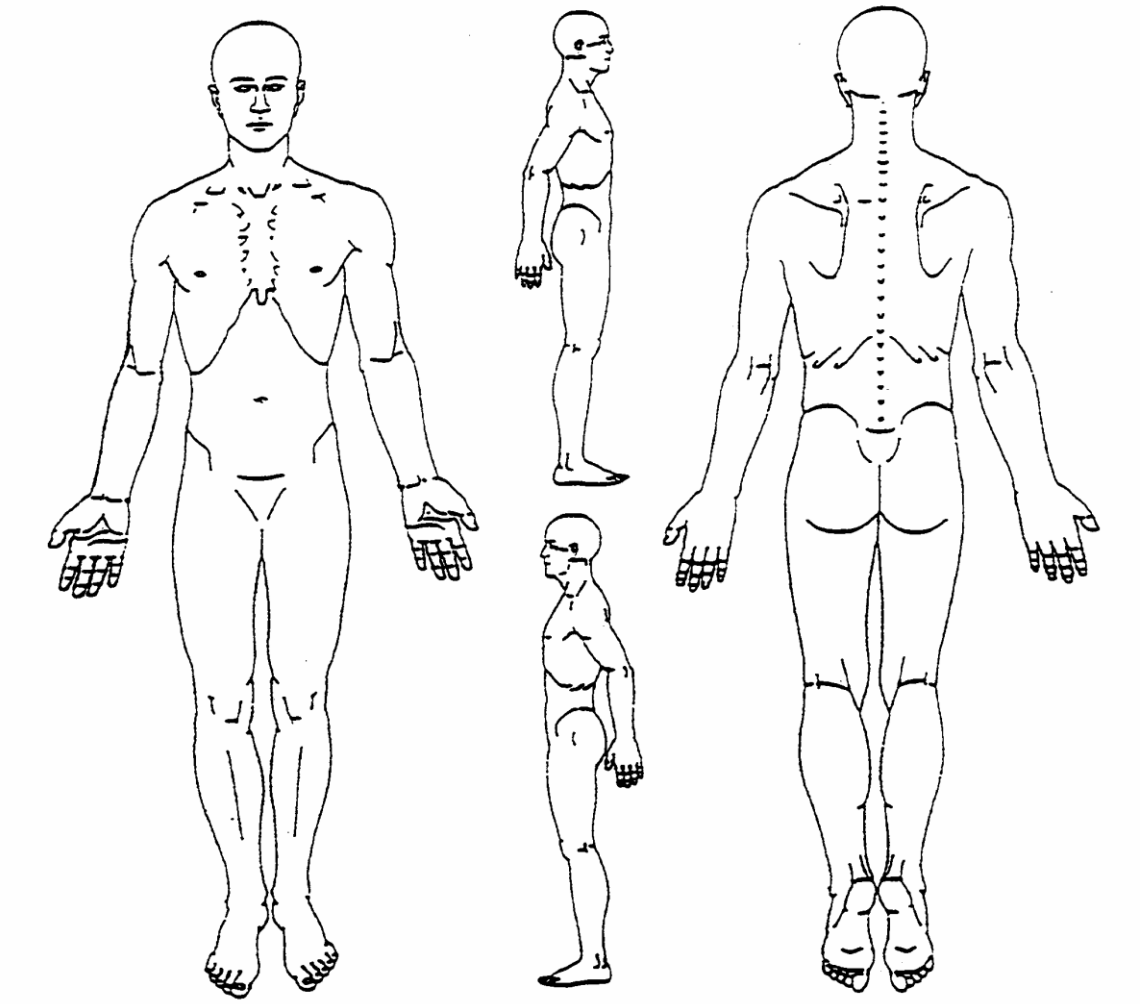
_____

Body Awareness Chart

Client Name: _____ Date: _____

Primary area of concern today: _____

On the diagrams below, please indicate by shading in the areas of your body where you are experiencing stress, tightness or discomfort. Pain and tension patterns are not the same thing as telling the therapist where to



work.

Please *indicate* below any ***hypersensitive*** areas where you are ***opposed*** to having treatment. Example: rash site, . . .

__ back	__ face	__ arms	__ legs	__ chest	__ neck
__ abdomen	__ gluteals	__ scalp	__ hands	__ feet	__ shoulders

Any additional information—changes in medication, new / recent illnesses. If on pain medication or anti-inflammatory meds at time of treatment, note it here. Reminder: If you have any acute symptoms such as common cold or flu, please ask your therapist to determine whether to reschedule. Massage may be contraindicated.

_____

_____

_____

Please indicate the perceived level of your stress, tightness or discomfort ***before*** and ***after*** treatment:

Before |----------|----------|----------|----------|----------|----------|----------|----------|----------|

Low 1 2 3 4 5 6 7 8 9 10 High

After Low |----------|----------|----------|----------|----------|----------|----------|----------|----------| High

1 2 3 4 5 6 7 8 9 10