MASSAGE PATIENT INTAKE – Heather Horst RN, BSN, CMT

Name _____ Date of Birth _____

Address _____ Home phone _____

City/State _____ Work _____

Email _____ Mobile _____

Emergency Contact _____ *(name)* _____ *(relationship)* _____ *(phone)*

Physician or NP, PA, etc _____ May I have your permission to contact your physician/provider? ❑ Yes ❑ No

What are your goals about receiving therapy?

Do you experience any pain or discomfort? *(please describe)*

Have you sustained an acute injury in the past 6 months? *(please describe)*

Have you experienced any type of trauma? Collision, injury, war, abuse, etc. *(please describe)*

Do you have any skin problems or allergies? *(please describe)*

Do you have any spinal problems? *(please describe)*

Do you have unusually high or low blood pressure?
(If yes, how is it managed?)

Do you have unusually high or low blood sugar?
(If yes, how is it managed?)

(continued on reverse side)

Have you ever had surgery? *(Please list, including approximate dates.)*

Are you pregnant? ❑ Yes ❑ No *(If yes, please note Estimated Date of Delivery.)* _____

Do you have any other medical conditions?

Please list any medications you use, either daily or as needed.

What is your occupation? _____ How does your work affect your body and your health?

Please describe your RESOURCES: what people, places, or activities make you feel GOOD?

I understand that the therapy offered here is for the purpose of health promotion: stress reduction, relief from pain and tension patterns, increased circulation, ease of movement, & awareness of my body.

I understand that massage and bodywork are not substitutes for medical examination, diagnosis, or treatment. I understand that I should see a physician or primary care provider for those services. I understand that neither a certified massage therapist nor a registered nurse can prescribe drugs or medical treatments.

I understand that massage and bodywork should not be performed under certain medical conditions. I affirm that I have disclosed all my known medical conditions. I agree to update Heather Horst about any changes in my health status.

I understand that a massage therapist may not perform high velocity spinal manipulations.

I understand that insurance does not cover massage therapy, and that Heather Horst will not bill insurance.

I understand that my health information is private, and that my Heather Horst will not disclose my confidential information without my express consent.

Client signature: *(or guardian)* _____ Date: _____