Massage Intake Form

Please fill out the following form. Use the back side of the form if more room is needed.

Today's Date: ___/___/___

Name: _____

DOB: ___/___/___ Age: _____ Height: _____ Weight: _____

Address: _____ City/State/ZIP: _____

Phone (Home)_____ (Work)_____ (Cell)_____

E-mail: _____

Current Occupation: _____

Emergency Contact: _____ (Phone)_____

Have you ever received professional massage or other bodywork modalities? Y/N _ if yes please list the modalities you have received (i.e Acupuncture, Shiatsu etc.): _____

_____

_____

Do you currently exercise? Y/ N _ if yes please describe: _____

_____

Briefly list your personal support system (i.e. family, friends, health care providers, groups): _____

_____

What do you wish to receive from your session? _____

_____

_____

Is there anything else you'd like me to know before we start our work? _____

_____

_____

_____

How did you hear about Thee House of Yoga Therapy? _____

How did you hear about my practice in particular? _____

NOTE: The following information requested, if you choose to provide it, will help me work more effectively with you.
Please fill in the following section for any condition for which you have been treated in the past two years that I should know about, including approximate dates and conditions.

General practitioner

_____

_____

Psychotherapist

_____

_____

Chiropractor

_____

_____

Psychiatrist

_____

_____

Homeopathic or Naturopathic Physician

_____

_____

Other (please list)

_____

_____

Please list below any prescription or non-prescription medication you are taking:

_____

_____

Please list any history of surgeries, major illnesses, chronic conditions, accidents, injuries or anything that might be relevant to doing our session which were not listed on the previous page:

_____

_____

Please check any condition that applies to you:

_____Addiction Recovery
_____AIDS
_____Anger
_____Anxiety
_____Arthritis
_____Asthma
_____Bulging or herniated disc
_____Chronic Fatigue Syndrome
_____Chronic Pain
_____Contact lenses
_____Degenerative disc disease
_____Depression
_____DID
_____Eating disorder
_____Emphysema or other breathing problem
_____Fibromyalgia
_____Fatigue
_____Fused vertebrae
_____Grief/Bereavement
_____Heart Condition
_____Hernia
_____High blood pressure: Type _____
_____Hepatitis: Type _____
_____History of Physical Abuse
_____History of Sexual Abuse
_____Insomnia
_____Low blood pressure
_____Menopause
_____Multiple sclerosis
_____Osteoporosis
_____Panic Attacks
_____Pregnancy:
How many months? _____
_____PTSD
_____Other _____
_____Other _____