

Howard Northrup Massage & Wellness

Confidential Health Intake Form

Full Legal Name _____ *Appt.* _____ *ID chk* _____
Street Address _____ City _____ State _____ Zip _____
Cell Phone _____ Home phone _____
E-mail address _____ Birth date _____ / _____ / _____
Regarding appointments & special offers, may I send you email messages? Yes / No Text messages? Yes / No
Would you like to learn how to get healthier with help from my email newsletter, *Wellness Tips*? Yes / No

Medical History and Information

Certain medical conditions may be contraindicated for massage or may need physician's approval.

Please mark a 'C' next to conditions that *Currently* apply or a 'P' for *Past* conditions:

<input type="checkbox"/> Stress	<input type="checkbox"/> TMJ (jaw)	<input type="checkbox"/> Pinched Nerves	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Shoulder Tight	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Depression	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Shooting Neck Pain	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Intestinal Gas
<input type="checkbox"/> Migraines	<input type="checkbox"/> Liver Function Problem	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sudden Muscle Pain	<input type="checkbox"/> Bulging Disk	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Anemia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Numbness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Face Flushed
<input type="checkbox"/> Stroke	<input type="checkbox"/> Tingling	<input type="checkbox"/> Cold Hands or Feet	Other: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Ringing in Ears	_____

Have you ever had a massage? _____ When was your last massage? _____ Where? _____

Check if any of these apply:

Sinuses get stuffed up when face down _____ Get chilly easily _____ High pain tolerance _____

List major injuries/surgeries/conditions within last 5 years:

List all prescriptions/herbs/vitamins currently taking:

What is your main activity every day (check all that apply)?

On phone _____ Sitting _____ Computer work _____ Driving car _____ Walking _____

What movements or activities (if any) are limited? _____

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

Florida law requires legal written consent for treatment of these sensitive areas of the body. Please check all items below that you agree to.

(Note: Your treatment results may be limited if a problem-specific body area is not worked)

- Gluteals (accessed at buttocks; associated with back, hip, & sciatic pain)
- Pectorals (accessed at upper chest, above breasts)
- Abdominals (accessed from below breasts to pubic bone; helpful for low back & hip pain)
- Psoas (accessed from abdomen near belly button to front hip bones; helpful for low back & hip pain)
- Iliacus (accessed from front hip bones to inner thigh; helpful for low back & hip pain)
- Adductors (accessed at inner thigh from knee to pubic bone)
- I do not consent to any of these areas

Please check to indicate your understanding that you will be draped as specified by Florida law at all times:

- Yes, I understand that only the body part or muscle group being worked on will be uncovered, then be recovered.
- I consent to receive treatment. I also understand that I can stop treatment at any time.

I am responsible for all charges for all services provided. 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. I understand that massage treatments are **not** substitutes for treatments by a qualified medical specialist. If I experience any discomfort during the massage, I will inform the therapist immediately. I waive any claim against the therapist and assume all risks of injuries that may result. I understand that any illicit or sexually suggestive remarks or advances will result in the **immediate termination** of the session.

Signature _____ Date _____