Howard Northrup Massage & Wellness

Confidential Health Intake Form

MA# 35627

Name _____ Appointment _____

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 **C**urrently apply or a '**P**' for **P**ast conditions:

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

_____

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 _____