

Howard Northrup, LMT

Confidential Health Intake Form

MA# 35627

Name _____ Appointment _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell 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 natural health tips by receiving 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 check all that currently apply or have applied in the past 5 years:

<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 (Now?)	<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	<input type="checkbox"/> Other:
<input type="checkbox"/> Asthma	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Other:

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 _____