Quality Health Massotherapy

2718 Sunset Boulevard, Suite D Steubenville, Ohio 43952
(740) 317-2219

Health Intake Form : Confidential Client Information & Health History

To give you the best care possible and address any and all medical issues, please complete this form to the best of your ability. Thank you!

Last Name | First Name | M.I. | Date of Birth

Address | Primary Phone | Secondary Phone

City | State | Zip Code

Email Address | Occupation

May we send you appointment reminders via email and/or text message? | Cell Phone

Email | Text | No reminders

Emergency Contact | Emergency Contact Phone | Relationship

Are you currently under the care of a physician, chiropractor, psychologist, or physical therapist for an ongoing or current problem?

Yes

No

Is your condition related to an accident or injury?

Describe accident and approximate date.

Yes

No

Have you had any major surgical procedures?

Describe procedure and approximate date.

Yes

No

____
Name (Last, First)

Are you currently taking any medications?

Please list medications.

Yes

No

Please list any known allergies.

Are you currently experiencing symptoms of any of the following conditions? (If you are actively ill, please make arrangements to reschedule your appointment. We reserve the right to refuse treatment for those that are ill to protect the health of our team members and other clients.)

Not actively ill | Flu | Cold
Infection | Contagious Disease | Fever

Please check any of the following musculoskeletal conditions below that currently affect you or that you have experienced in the last 5 years

None | Spasms/cramps | Sprains/strains
Fibromyalgia | Tendonitis | Bursitis
Postural deviations | Osteoporosis | Osteoarthritis
Rhumatoid arthritis | Decreased range of motion | Gout
TMJ | Torticollis (Stiff Neck) | Whiplash
Frozen Shoulder Syndrome | Arm pain | Shoulder pain
Carpal tunnel syndrome | Thoracic Outlet Syndrome | Radial nerve compression
Low,mid, upper back pain | Hip pain | Sciatica
Knee pain | Ankle pain | Foot pain
Plantar fascitis | Other

Please check any of the following circulatory conditions below that currently affect you or that you have experienced in the last 5 years.

None | Hypertension | Low blood pressure
High cholesterol | Heart condition | Blood clots
Diabetes | Anemia | Hemophilia
Varicose veins | Reynaud's disease
Other

Please check any of the following respiratory conditions below that currently affect you or that you have experienced in the last 5 years.

None | Sinusitis | Dizziness | Asthma
Trouble breathing | Pneumonia | Other

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Name (Last, First)

Please check any of the following skin conditions that currently affect you or that you have experienced in the last 5 years.

None	Open wound or sore	Acne
Warts	Moles	Athlete's foot
Fungal infection	Dermatitis	Eczema
Psoriasis		
Other		

Please check any of the following digestive conditions below that currently affect you or that you have experienced in the last 5 years.

None	Gastro-esophageal reflux disease
Indigestion	Ulcers
Gas/bloating	Food intolerances
Gallstones	Hepatitis
Ulcerative collitis	Crohn's disease
Diverticular disease	Irritable Bowel Syndrome (IBS)
Other	

Please check any of the following other conditions below that currently affect you or that you have experienced in the last 5 years,

None	Insomnia
Sleep apnea	Headaches
Cluster headaches	Migraines
Depression	Post-Traumatic Stress Disorder
Anxiety/Panic attacks	Suicidal thoughts
Seasonal Affective Disorder (SAD)	Grief process
Substance abuse	Physical/emotional abuse
Premenstrual Syndrome (PMS)	Environmental sensitivities
Pregnancy	Postpartum depression/Baby "blues"
Chronic fatigue	Cancer
HIV/AIDS	Lupus
Thyroid disease	Kidney disease
Liver disease	Bladder infection
Pelvic inflammatory disease	Fibroids/ovarian cysts
Endometriosis	
Other	

Name (Last, First)

Is this your first professional massage?

Yes

No

Is stress affecting your health and wellness?

Yes

No

Please indicate which best describes your current level of stress.

Not stressed

Mildly stressed

Moderately stressed

Very stressed

Beyond stressed

Pleas indicate which best describes your current level of exercise & state of health.

Sedentary

Light Exercise

Moderate Exercise

Exercise 5-7 days per week

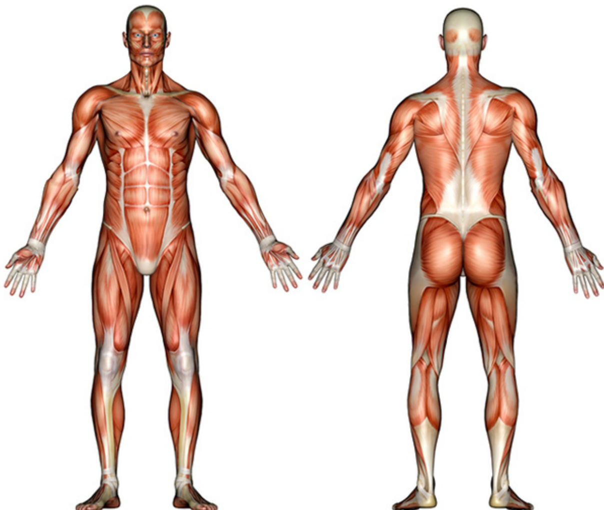
Feel unhealthy (tired, dull skin and hair, lack of energy)

Feel fairly healthy (make good diet & exercise choices, good energy)

Feel healthy (skin, hair, and nails healthy, high level of energy)

What types of exercise do you engage in regularly?

What do you hope to accomplish from massage?



Look at the diagram on the left, then close your eyes briefly and perform a body systems check. How does your body feel to you? What pains have you been experiencing lately?

Please describe any issues you've currently been experiencing with your body an how you'd like your therapist to help you with those areas.

Is there any other information that your therapist should be aware of that has not yet been covered in this form?

Name (Last, First)

Consent for Care:
I understand that the therapists at Quality Health Massotherapy do not practice medicine or chiropractic health care services. I understand that there are contraindications to massage and I affirm that I have states all my known medical conditions and answered all questions honestly and accurately. I also understand that treatments involving heat, such as hot stones, may subject my skin to burns due to my skin type and condition, and will not hold Quality Health Massotherapy liable. I agree to keep Quality Health Massotherapy updated on any change in my medical condition.

Payment is due upon completion of the therapeutic service. Please make checks payable to Quality Health Massotherapy, LLC. Returned checks will be assessed a $30.00 charge. If you are unable to keep an appointment, please notify us at least 24 hours prior to the appointment. Appointments which have not been cancelled within the specified time frame will be billed directly to the client. Client services and chart information are strictly confidential. Written authorization is required from you to release information. I have read the above statement, agree to the terms, and declare that the provided health information is accurate.

By entering my name below, I am acknowledging and agreeing to all statements listed above and further affirm that everything on the health intake form is accurate and complete.

Today's Date