Concordia Wellness, LLC HEALTH INTAKE FORM

Name _____ Pronouns _____

Address _____

Phone _____ Email _____

Date of Birth _____ How did you hear about us? _____

Emergency Contact Name & Phone _____

If you are using insurance benefits to cover part or all of your massage:

Insurance Company Name _____ *Policy or ID#* _____

Gender: _____ ***Important Note: Contact us to confirm your benefit before your appointment***

What are you hoping to gain from massage? _____

_____

When was your last massage? _____

Prescription Medications	Reason Taken	Side Effects
1. _____	_____	_____
2. _____	_____	_____

Other Medications: _____

Please list any injuries in past 5 years, and any prior injuries that have caused lasting impacts

_____

Please list any surgeries in past 5 years, and any prior surgeries that have caused lasting side effects

_____

Allergies _____ Pregnant? Y N If yes, due date _____

How many hours per day do you . . .

exercise? _____ sit at a computer? _____ sleep? _____

Do you have any illnesses or symptoms of illness? Y N

If yes, what are they and how long have you had them? _____

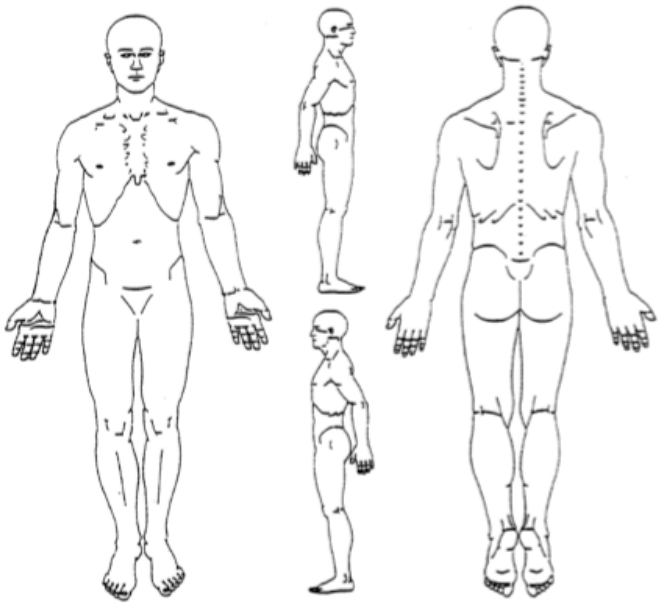
_____

Are you experiencing pain? Y N If yes, how long have you had this pain? _____

Indicate on this diagram where you are experiencing pain/discomfort:

Indicate any of the following conditions that you have now or have had in the past:

- ☐ Blood clotting disorders
- ☐ Heart/Circulatory problems
- ☐ High/Low blood pressure
- ☐ Kidney conditions
- ☐ Acute Anxiety/Depression
- ☐ Stroke
- ☐ Allergies:_____
- ☐ Skin conditions
- ☐ History of trauma
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Cancer
- ☐ Embolism/DVT



Are you under the care of a physician? Y N

If yes, for what condition(s)? _____

List any preferences for comfort, such as lighting, heat, music, or areas to avoid: _____

_____

Please list any other conditions that you have or have had that affect your life in important ways

_____

_____

☐ ***Send me occasional (<u>not</u> frequent) informative emails including our stellar quarterly newsletter***

Consent: I understand that there are conditions for which massage therapy may be contraindicated. I have completed this Health Intake Form truthfully and to the best of my knowledge. I understand that with any treatment certain risks are involved and that complications or side effects could occur. I freely assume these risks, and I agree that I will not hold Concordia Wellness, LLC, or Massage Therapists practicing at Concordia Wellness, LLC, liable for any effects from my session.

Client Signature _____ Date _____