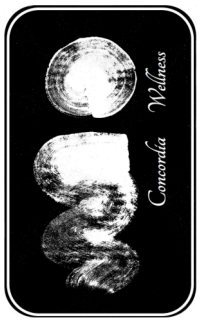


Concordia Wellness HEALTH INTAKE FORM

Name _____ Date _____

Address _____

Phone _____ Email _____

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

Emergency Contact Name_____ Phone _____

What are you hoping to gain from massage? _____

_____

When was your last massage? _____

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

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 _____ Females: 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

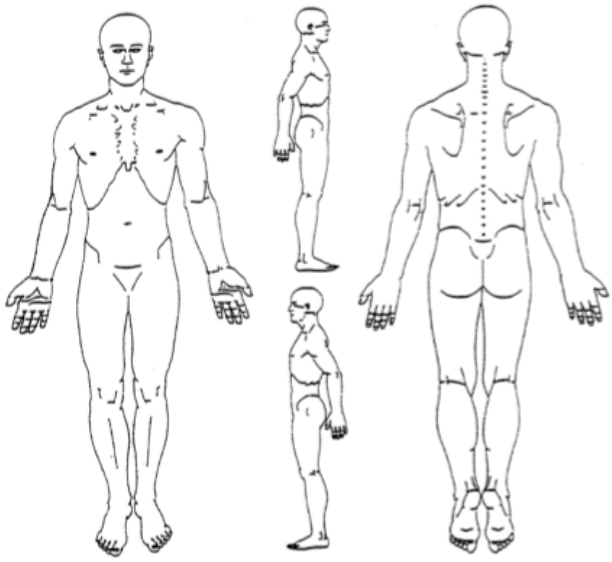
If yes, what are they and how long have you had them? _____

_____

Concordia Wellness HEALTH INTAKE FORM

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

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



Are you under the care of a physician? Y N

If yes, for what condition(s)? _____

_____

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

- ☐ Circulatory conditions
- ☐ Heart problems
- ☐ High/Low blood pressure
- ☐ Kidney conditions
- ☐ Acute Anxiety/Depression
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Hemophilia
- ☐ Skin conditions
- ☐ Serious injuries
- ☐ Embolism/Deep-
- ☐ Asthma
- ☐ Cancer

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

_____

☐ ***Include me in emails with relevant articles, new services, promotions, and raffle drawings***

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 Kim Magraw or Concordia Wellness liable for any effects from my session. I understand that services rendered by Kim Magraw and Concordia Wellness are strictly professional.

Client Signature _____ Date _____