Adrienne G. Honeywell, L.M.T.

massage therapy
patient intake form

Confidential Patient Information

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Please list the telephone number you wish to receive calls about your appointments, or other health related information if different than your home phone number: _____

Marital Status: _____ Profession: _____

Birth Date: _____ Age: _____ Sex: ○ Male ○ Female

Have you ever had massage before? ○ Yes ○ No

If yes, when was the date of your last massage? _____

Who can we contact in an emergency? (Name) _____

(Phone) _____

How are you related to this person? _____

Name of Medical Doctors: Date of Last Visit:

Primary Care Physician_____ _____

Chiropractor _____ _____

Acupuncturist _____ _____

Dentist _____ _____

Other _____ _____

How did you hear out about i spa?

Referral _____, internet, yellow pages, other _____

May we add you to our monthly e-mail newsletter list, filled with health tips, information about our upcoming events and other valuable health related resources? ○ Yes ○ No

Medical History

Please list any health conditions/discomforts you are currently seeking treatment for:

_____

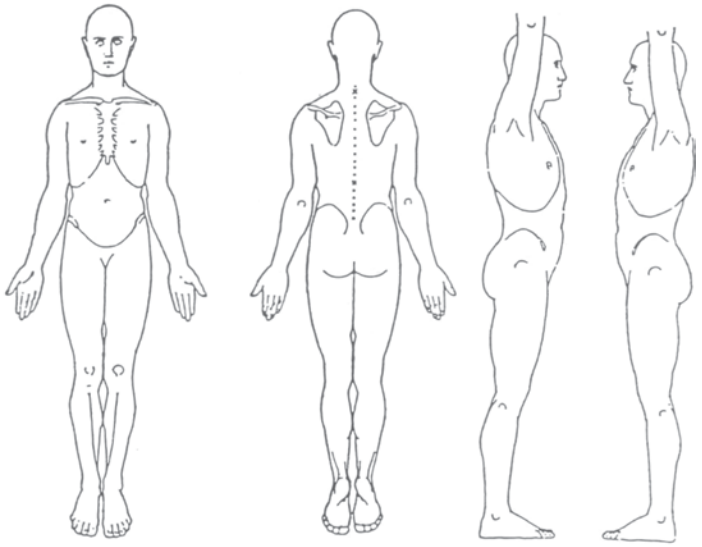
Are you in pain now? ○ Yes ○ No

Please locate the area of pain on the diagrams to the right:

X for pain

O for stiffness

N for numbness



Have you had previous treatment for the above complaint? _____

○ Massage Therapist ○ Chiropractor ○ Acupuncturist ○ Medical Doctor ○ Other

How long have you experienced this condition? _____

Have you taken any medications prior to your arrival to i spa? ○ Yes ○ No

If yes, please list: _____

Are you on any medication right now? ○ Yes ○ No If yes, which one(s)? (Please include any birth control, supplements/vitamins as well) _____

_____

Please circle any frequent habits you have: tobacco coffee tea soda alcohol non-prescription drugs

Are you allergic to any oils or creams? ○ Yes ○ No If yes, which one(s)? _____

_____ Do you stretch regularly? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No If yes, how often do you exercise? _____

Please list any previous injuries:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____ Continue on back if needed.

Medical History (continued)

Please indicate with an X if you have/had any of the following conditions:

head / neck		
current	previous	
		tension headache
		sinus headache
		migraine
		vision problems
		contact lenses
		earaches
		hearing problems
		herniated disk

cardiovascular		
current	previous	
		high blood pressure
		low blood pressure
		poor circulation
		heart disease
		stroke
		varicose veins
		phlebitis
		pacemaker

respiratory		
current	previous	
		asthma
		chronic cough
		shortness of breath
		bronchitis
		emphysema

muscle / joint pain		
current	previous	
		neck
		lower back
		mid back
		upper back
		shoulder: left right
		hip: left right
		leg: left right
		knee: left right
		ankle: left right

digestive / urinary		
current	previous	
		digestive problems
		constipation/diarhea
		liver / gall bladder
		kidney / bladder
		colitis / crohn's
		diabetes
		ulcers

Please note any of the following:	
	pins
	wires
	artificial joints
	body jewelry

infectious conditions			type
current	previous		
		tuberculosis	
		AIDS/HIV	
		hepatitis	
		infectious skin condition(s)	

skin			type / location
current	previous		
		skin condition(s)	
		bruise easily	
		plantar warts	
		loss of sensation	
		eczema / psoriasis	

Medical History (continued)

Please check any other conditions that you have been diagnosed with:

- ○ epilepsy
- ○ fibromyalgia
- ○ polio/post-polio
- ○ arthritis
- ○ hemophilia
- ○ osteoporosis
- ○ scoliosis
- ○ chronic fatigue
- ○ cancer
- ○ thyroid disease
- ○ other, please list _____

Females: Are you pregnant? ○ Yes ○ No

I certify that the information that I have included in this form is accurate to the best of my knowledge.

Patient Name: _____ (please print name)

Signature of Patient/Guardian: _____ Date: _____