Nature's Touch
NATUROPATHIC CLINIC

CONFIDENTIAL MASSAGE INTAKE FORM

(please print clearly)

Name:_____Date_____

Date of birth :_____ (M/D/Y) Sex: M __ F__Non-Binary___
Address:_____
_____
_____

EmailAddress:_____
Empower your Health with monthly health tips by Nature's Touch: YES____ NO_____

Telephone number:Home:_____Work:_____

May we leave messages or email relating to your visits? YES_____ NO_____

Emergency contact: Name:_____
Phone number:_____
Relation:_____

**An accurate health history form is important to ensure a safe massage treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

How did you hear about our Clinic?_____

If referred, who were you referred by:_____

Other health care providers you are seeing:

1._____
2._____

What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Previous Surgeries/Serious
Illnesses:_____
_____

Pervious Injuries including motor vehicle accidents:_____
_____

Do you have any Pins/Wires/Artificial Joints? Y N Where?_____

Have you had massage therapy in the past? Y N
If yes, how often?_____ When was your last treatment?_____

On what areas do you want to focus treatment?_____

Is there any areas you would prefer ***not*** to receive therapy?
_____

Review of Systems Checklist:

Cardiovascular	**Head and Neck**
☐ High blood pressure ☐ Low blood pressure ☐ Chronic congestive ☐ Heart failure/Heart attack/Heart Disease ☐ Phlebitis/ varicose veins ☐ Stroke/ CVA ☐ Pacemaker or similar device ☐ Dizziness/ vertigo ☐ Seizures Is there a family history of any of the above? Yes _____ No_____	☐ History of headaches ☐ History of migraines ☐ Vision problems ☐ Vision loss ☐ Ear problems ☐ Hearing loss

Infectious Conditions

☐ Skin conditions

Describe:
_____

☐ Respiratory conditions

Describe:
_____

☐ Hepatitis

Respiratory

☐ Asthma

☐ Bronchitis

☐ Emphysema

☐ Chronic Cough

☐ Shortness of Breath

Is there a family history
of any of the above?

Yes_____ No_____

Muscle /Joint

☐ Neck

☐ Back (lower)

☐ Back (mid)

☐ Back (upper)

☐ Shoulders

☐ Elbow

☐ Wrist/ Hand

☐ Hip

☐ Knee

☐ Ankle/ Foot

☐ Spine

☐ Arthritis

Is there a family history of
arthritis? Yes_____ No_____

Women

Pregnancy Due date:
_____

Previous pregnancy
complications_____
_____

Menopausal problems _____
_____

Menstrual problems
_____

Gynecological
conditions: what?
_____

Digestive	**Skin Condition**
☐ Constipation ☐ Crohn's Disease ☐ Colitis ☐ Irritable bowel syndrome (IBS) ☐ Ulcers	☐ Eczema ☐ Psoriasis ☐ Rash ☐ Warts ☐ Open sores
Mental/Emotional	**Other**
☐ Anxiety ☐ Depression ☐ OCD ☐ Irritability/Mood issues	Diabetes Onset:_____ Type:_____ Loss of sensation: Where? _____ Allergies/hypersensitivities What?_____ ☐ Epilepsy ☐ Cancer Type/Location_____ ☐ Hemophilia ☐ Fibromyalgia ☐ Chronic fatigue ☐ Scoliosis ☐ Polio/ Post Polio

Informed Consent

If you have any questions regarding the following information, please do not hesitate to ask. It is important that you are fully aware and understand your rights, the treatment procedure, and any policies. This will assist you in making an informed decision in regards to massage therapy.

Treatment possibilities will be discussed with the client in advance and the client may refuse or agree to treatment (or any aspect of treatment) at any time regardless of prior consent. The client will determine which area of body will be worked on. The client has the right to decide which articles of clothing will remain on at the time of the massage. Being fully draped or fully clothed during a treatment is also an option.

If any of the following area (inner thigh, gluteal/ buttock, abdominal, breast) are to be included into treatment, the therapeutic indications and treatment procedure will be discussed by the client and the therapist and additional consent will be given prior to undraping/ treating these area. The client has the right to privacy and confidentiality.

There will be a 15 minute assessment and health history taken which must occur before the first massage is performed. Your cooperation is appreciated as this is an important tool in assisting the therapist in designing a treatment plan. The client may experience some stiffness and/ or soreness due to the manipulation of specific soft tissue areas.

I understand the information given on this form is absolutely confidential and will be released to other health care professionals or legal representative only with written consent. I understand that 24-48 hours notice is required to reschedule my appointment, otherwise full scheduled fee will be charged.

I have read, and fully understand all the information in this consent document. I will ask the therapist regarding anything that was unclear. I confirm that I am capable of consenting to treatment. I acknowledge that my consent is voluntary and I understand that I may withdraw my consent at anytime. I hereby consent to participate in this therapeutic relationship.

Date_____ Signature_____

Date of initial Health History:
_____
Update 1_____
Update 2_____
Update 3_____
Update 4_____
Update 5_____