

Fifth Element Massage Health Intake Form

Name _____ Date _____
Street _____ City _____ State _____ Zip _____
Telephone(home) _____ (cell) _____ (other) _____
Email Address _____ Occupation _____
Date of Birth _____ Insurance _____
Policy # _____ Group # _____
Referred by _____
Reason for therapeutic massage? _____
When and how did this condition develop? _____
List all surgeries _____
List all accidents _____
Are you currently seeing a medical practioner? (MD, Chiropractor, Physical
Therapist, Acupuncture) _____

What vitamins, herbs and medications do you currently take?

Please check all of the following that currently apply to you:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Edema
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS	<input type="checkbox"/> PMS	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Depression	<input type="checkbox"/> Hernia	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Neck Pain		<input type="checkbox"/> Back Pain		<input type="checkbox"/> Chest Pain	
<input type="checkbox"/> TMJ Pain		<input type="checkbox"/> Herniated Disc		<input type="checkbox"/> Broken Bones	
<input type="checkbox"/> Heart Condition		<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Respiratory Problems		<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/> Stomach Disorders	
<input type="checkbox"/> Varicose Veins		<input type="checkbox"/> Menstrual Pain		<input type="checkbox"/> Skin Disorders	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Contacts		<input type="checkbox"/> Hearing Aid	

Do you have any health conditions not listed above? Explain

I understand that massage practioners do not diagnose illness, disease, or other physical or mental disorders. Massage practioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for a physical ailment that I might have. I have stated all my known medical condition and take it upon myself to keep the massage practioner updated on my physical health.

Signature _____ Date _____