Wildwood

Massage Intake Form

Date:_____/_____/_____

PATIENT INFORMATION

Name: Phone (primary):

Date of Birth (mm/dd/yyyy): / / Gender:

Street Address:

City: Zip:

E-mail: Primary Physician

Emergency contact: Phone:

How did you hear about Wildwood

Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.

MEDICAL INFORMATION

Are you taking any medications? ___ Yes ___ No
If yes, please list name and use:

_____

_____

_____

_____

Are you currently pregnant? ___ Yes ___ No

If yes, how far along?_____

Any high risk factors?_____

Please indicate any condition you have had in the past or currently have.

__Cancer
__Headaches/Migraines
__Arthritis
__Diabetes
__Joint Replacement(s)
__High/Low Blood Pressure
__Neuropathy
__Fibromyalgia
__Stroke
__Heart Attack
__Kidney Dysfunction
__Blood Clots
__Numbness
__Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

INDICATE AREAS OF PAIN/TENSION

On a scale from 1-10, 10=highest, rate your levels of:

Stress: ____ Pain: ____ Energy: ____

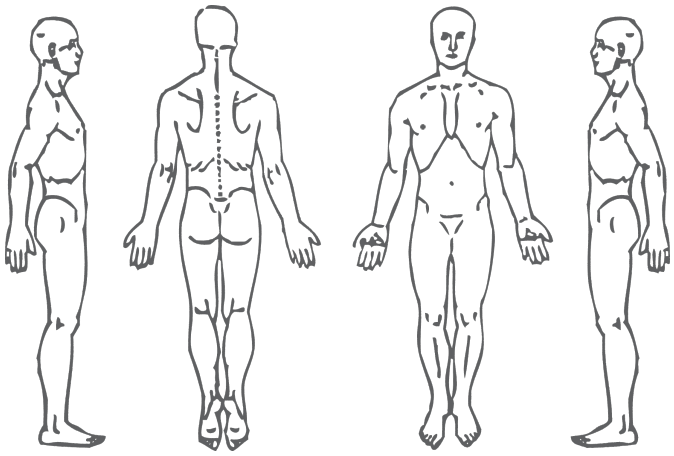
How did your symptoms begin and when did they start?

_____

_____

What have you done for relief? _____

Is the condition getting better/worse? _____



Please circle any areas of discomfort.