Love Life Massage & Wellness

Health History & Intake Form

Name:_____ Home#:_____Cell#:_____

Address:_____City:_____ State:_____ Zip:_____ Email:_____

D.O.B: __/__/__ Age:___ Sex: M___ F___ Height:____ Weight:____ Are you nursing or pregnant: Y___N___

Smoker/Tobacco/Drug user: Y___ N___ for how long:____ Marital Status: S M W D. Number of children:___

PCP:_____ Occupation:_____Work#: _____Level of stress daily 1-10:___

Emergency Contact:_____ Relation:_____ E.C#:_____

History of health & healthcare:_____

Are you currently under the care of another practitioner; if so who, for what? _____

Current medications/vitamins/supplements; dose and purpose:_____

_____

Injuries/surgeries/accidents:_____

_____

Present health concerns:_____

_____

Please circle any of the following that apply to you:

Arthritis	Fibromyalgia	Asthma/Hay Fever/Hives	Lyme Disease	Bleeding Disorder
Cancer	Heart Disease	Epilepsy/Seizures	Diabetes	HIV/AIDS
IBS	Anxiety	Hepatitis: A B C	High Blood Pressure/Cholesterol	
Fever	Thyroid Problems	Addiction/Psychological Issues:_____		Depression
Dizziness/Fainting		Eating Disorder	Menstrual Issues	Sinus Issues
Allergies:_____		Breathing Issues:_____	Cysts/Tumors	Menopause
Pulled/Torn/Sore/Swollen Muscles/Joints:_____			Hearing Issues/Difficulty/Aid	
Memory Issues		Chronic Disease:_____	Headaches/Migraines	STD_____
Back Pain	Circulation Issues	Kidney/Stomach/Bladder Issues	Sleep Difficulty	MS
Neuropathy	Referred Pain	Eye Issues/Glasses/Contacts	Varicose Veins	Other:_____

_____

Additional Explanations for circled above:_____

_____

Have you ever had a massage before: Y__ N__ How long ago:_____ Pressure:_____

What are you looking to gain out of your treatment(s):_____

Any area that you would NOT like worked on:_____Any area in need of extra attention:_____

How did you hear about us? _____

*I am aware and in compliance with: Love Life Massage & Wellness' **Code of Ethics & Standards of Professionalism .** I am also aware that any deliberate misinterpretation of this form may jeopardize my own health, or that of my practitioner. I understand that all given information and treatments are completely confidential until written consent/permission is granted.

_____ _____ _____

PRINT SIGNATURE DATE