



body | balance realign. reconnect. recover.

Confidential Health Intake

Name: _____ Today's Date: _____

Address: _____
Number Street City State Zip

Date of Birth: _____ Marital Status: _____ Number of Children: _____

Gender identity/preferred pronoun(s): _____

Primary Phone: _____ Home Cell Work Preferred

Secondary Phone: _____ Home Cell Work Preferred

Emergency Contact: _____ Phone: _____

Email: _____

Only for occasional communication from our office, circle one: Opt IN Opt OUT

Occupation: _____ Employer: _____

What do you
Physically do at work? _____

Pregnant or nursing now? _____ Miscarriages or terminations and dates: _____

Dentures or Dental appliances? _____ Orthotics or inserts in your shoes? _____

Most recent massage or Rolfing session: _____ Who may we thank for referring you? _____

Primary physician: _____
Name Phone number

If you are currently being treated by a doctor for something specific, please explain and give doctor's name and specialty: _____

Please list ALL medications and supplements you are currently taking and why: _____

List all previous injuries, injections, and surgeries and give approximate dates: _____

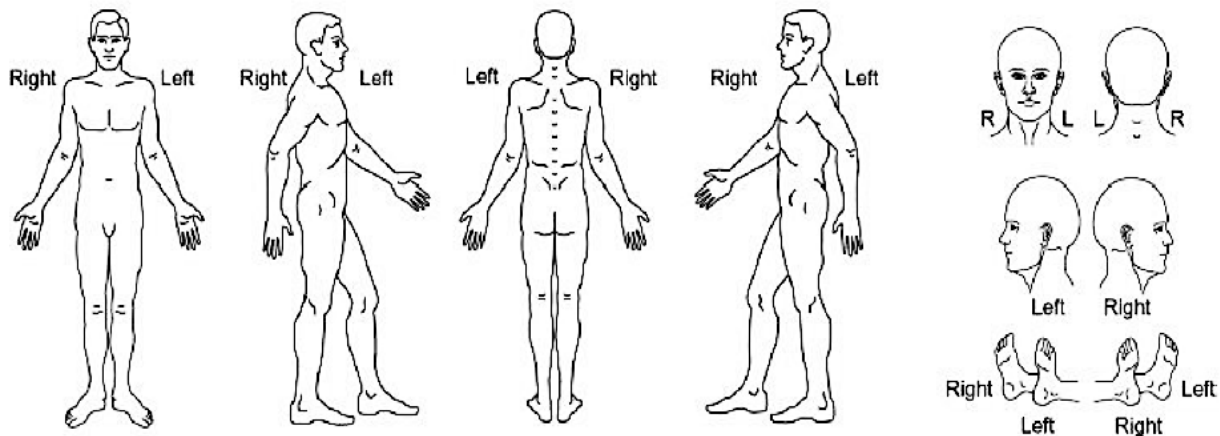
Exercise (Types and Frequency): _____

Caffeine: Quantity _____ Frequency _____
 Alcohol: Quantity _____ Frequency _____
 Tobacco: Quantity _____ Frequency _____
 Sugar: Quantity _____ Frequency _____
 Water: Quantity _____ Frequency _____

If you have pain: When did it start? What caused it? Where is it? How often do you feel it? On a 1-10 scale (10 being highest), indicate the location(s), intensity, & type of pain (dull, sharp, deep, superficial, shooting, tingling, burning etc.): _____

What do you do for pain management?): _____

Please SHADE ALL AREAS PAIN, DISCOMFORT, AND STIFFNESS, regardless of severity:



Please CHECK all areas of pain, injury, or health condition that apply:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Joint pain/ immobility | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Arthritis or bursitis | <input type="checkbox"/> Open sore/wound |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Muscular cramps | <input type="checkbox"/> Depression | <input type="checkbox"/> MS or CP |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> TMJ dysfunction | <input type="checkbox"/> Stress | <input type="checkbox"/> Phlebitis/history of blood clots |
| <input type="checkbox"/> Mid back | <input type="checkbox"/> Night guard/splint | <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Contagious health/skin condition |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Nervousness/anxiety | <input type="checkbox"/> Implants – type/location |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Menstrual problems | |
| <input type="checkbox"/> Leg/knee | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Ankle/foot | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Other health condition(s) (please list) |
| <input type="checkbox"/> Arm/hand/wrist/fingers | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | |