Bonnie McNairn, Licensed Massage Therapist, PO Box 1055, Taos, NM 87571 (575) 770-4031

Confidential Health Intake Form

Name ____ Date of Birth ______________________________

Street Address/Mailing Address ____

City___________________ State_____ Zip________ Phone Number _________________________________

Email ___________________________ Please circle your preferred form of contact: phone text email

Emergency Contact & Ph #: ____

Occupation/employer: ____

Who referred you? ____

Please describe the main reason for your visit today and what you would like from your session:

____

What movements or activities are limited, including sleep?____

____

Level of pain from 0 to 10, where & how often? ____

____

What seems to help the condition the most? ____

____

What seems to aggravate the condition the most?____

Have you lost work from this condition (how many days)? ____

What is your main activity at home or work? ____

List physical activities you participate in regularly: ____

Have you experienced increased stress recently? ____

What do you do to relieve stress?____

Describe the dates and events of this injury or accident: ____

____

List all current medications/herbs/vitamins and dosage: ____

____

List diagnoses and treatments you have received for this, how often and from whom (doctor, acupuncture, physical therapy, chiropractic, naturopathic, etc): ____

____

List other major injuries/surgeries/complications/unusual diseases: ____________________________________

____

List any known allergies: ____

Please indicate for each of the questions below: 1. presently have or 2. previously had

Musclo-skeletal System

___ low back problems
___ pain between shoulders
___ neck problems
___ arm problems
___ leg problems
___ hip problems
___ stiffness
___ painful or stiff joints
___ muscle pain
___ weak muscles
___ walking problems
___ sprains/strains
___ arthritis
___ broken bones
___ tendonitis
___ scoliosis
___ vertebra or disc problems

Eye, Ear, Nose & Throat

___ vision problems
___ eye pain or inflammation
___ ear pain
___ ear noise
___ hearing loss
___ sinus problems
___ difficult nose breathing
___ jaw pain/teeth grinding
___ difficulty chewing
___ difficulty swallowing
___ mouth, teeth, gum pain
___ hoarseness or speech difficulty
___ sore or swollen throat

Nervous System

___ headaches
___ numbness/tingling
___ dizziness or fainting
___ muscle jerking
___ convulsions
___ confusion
___ fatigue
___ depression
___ anxiety
___ sleep difficulties
___ migraines

Skin

___ rashes, acne, warts, fungus
___ sunburn or inflammation
___ skin sensitivity
___ painful scars
___ allergies to lotion or oils

Cardio-Vascular System

___ varicose veins
___ high/low blood pressure
___ blood clots, thrombosis
___ aneurism
___ chest pain
___ rapid heart beat
___ heart problems
___ difficulty breathing
___ persistent cough
___ lung problems

Urinary System

___ excessive urine
___ scanty urine
___ painful urination
___ discolored urine

Reproductive System

___ endometriosis
___ menstrual pain
___ menstrual clots
___ interruption in menstrual cycle
___ current pregnancy
___ prostate problems
___ pelvic pain

Gastro-Intestinal System

___ poor appetite
___ excessive hunger
___ excessive thirst
___ nausea
___ vomiting: food, bile or blood
___ abdominal pain
___ diarrhea
___ constipation
___ black stool
___ yellow or white stool
___ hemorrhoids
___ liver or gall bladder trouble
___ weight trouble

General

___ cancer/tumors
___ diabetes
___ osteoporosis
___ rheumatoid arthritis
___ auto immune disorder
___ heart disease
___ stroke
___ digestion issues
___ infectious disease
___ ruptured organs
___ removed organs or lymph nodes

Cancellation Policy, Massage & Health Condition Agreement:

I ________________________________ (printed name of Client) give my consent for massage. I will consult my Licensed Massage Therapist (LMT) with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my LMT informed of any changes. I agree to provide **24 hour cancellation notice** for any appointments I have made. If I cancel within 24 hours or fail to arrive for my appointment, I agree to pay the full appointment fee. Payment for cancellation within 24 hours of appointment or "no-shows" is due immediately and shall be paid before the next treatment session.

Signature ____ Date ____________________________