Adirondack Salt Cave Health History Intake Form

Confidential Information

Name: _____ **Date of Birth: ____/____/___**

Phone: _____ **E-mail:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Have you received massage therapy before? Yes ___No___

What type of pressure do you prefer? Light ___Moderate ___Deep ___Not sure___

What is your occupation? _____

What are the expectations/goals for this massage session? _____

Have you had any current surgeries? _____ (within the last 2 years)

Explain: _____

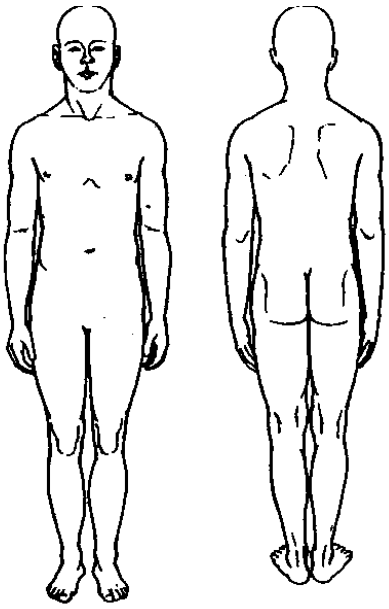
Do you have any allergies to oils or lotions? _____sensitive skin (y/n)? _____

Are you pregnant? _____how many weeks? _____

Do you have any of the following (circle)

Abdominal Pain	Fibromyalgia	Anemia
Accident	Headaches	Jaw Pain/TMJ
Allergies	Heart Disease	Multiple Sclerosis
Arthritis	High Blood Pressure	Osteoporosis
Bursitis	HIV	Pacemaker
Gout	Joint Pain	Parkinson's Disease
Broken Bones	Lower Back Pain	Hernia
Blood Clots	Mid Back Pain	Glaucoma
Cancer	Nervous Tension	Lymphedema
Colitis	Sprains/Strains	Bronchitis
Diabetes	Stroke/Seizures	Pinched Nerve
Disc problems	Varicose Veins	Prosthesis
Sinus Problems	Tendonitis	Thyroid Issues
Tumors or Growths	Ulcers	Whiplash

Please indicate areas you feel discomfort or need attention:



Medications: _____

Primary Physician: _____Phone #:_____

Emergency Contact: _____Phone #:_____

PLEASE READ AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I will inform my therapist of any changes in my health or medications prior to each session.
- I am responsible for paying for any missed appointment or cancellation less than 24 hours.

Signature: _____**Date:**_____