Health Intake Form

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1. Patient & Contact Information

Complete this entire intake as much as possible to the best of your ability and comfort level. The more information I have about your health, the more effective treatment plan we can implement. It may take 10-20 minutes depending on your health history but I encourage you to take your time and complete it as thoroughly as you are able. Please be aware there are multiple pages.

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________________ Pronoun/Nickname Preference? ______________________

E-mail Address: ______________________ Cell Phone: ______________________

Home Phone: ______________________ Work Phone: ______________________

Preferred Contact Method
○ e-mail ○ text cell phone ○ call cell phone ○ call home phone ○ call work phone

Street Address: ____________ Apt./Unit #: ____________ City: ____________ State: ____________

Occupation: ______________________ Emergency Contact Name & Phone Number ______________________

2. Primary Health Care Provider

Provider/Doctor's Name: ______________________ Phone Number: ______________________

Fax Number: ______________________ Address: ______________________

NOTE: I will not contact your health care provider without your permission and swear to safeguard client confidentiality unless disclosure is required by law.

3. Medications

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4. Treatment Goals

Primary Goals for Treatment (select 1-3):

☐ Reduce Anxiety/Destress ☐ Sleep Better ☐ Improve Quality of Life ☐ Reduce Pain and Tension
☐ Lower Blood Pressure ☐ Improve Athletic Performance ☐ Motor Vehicle Collision Recovery
☐ Pre/Post Surgery Care ☐ Injury Rehabilitation ☐ Other (please explain below)

Elaborate on your Treatment Goals: ______________________

Areas to Avoid: ______________________

List your current health concerns that bring you to massage therapy (e.g., low-back pain, headaches, anxiety, post-surgery pain, poor posture, etc.).

Primary Health Concern: ______________________

Secondary Health Concern: ______________________

Tertiary Health Concern: ______________________

Other Health Concerns: ______________________

Other Treatments Received or Receiving: ______________________

Activities Limited by Conditions: ______________________

Exercise Activity & Frequency: ______________________

Self-Care Routines: ______________________

5. Health History

List and explain. Include dates and treatments received. Go as far back as you can, it all matters.

Surgeries:

____

____

Injuries, Accidents:

____

____

Major Illnesses, Hospitalizations:

____

____

Do you have any mobility concerns?
☐ yes (feel free to explain in the next section) ☐ no

Mobility Concerns:

____

Check all that apply to your (more or less) daily life:
- ☐ sit for long periods of time ☐ stand for long periods of time
- ☐ repetitive movements in work, sports, play, or home life
- ☐ moderate to significant stress in work, home, or other aspects of your life ☐ bad bed ☐ bad sleep
- ☐ ergonomic workspace ☐ a regular physical therapy routine ☐ a regular exercise routine
- ☐ a regular self-care routine ☐ 20 minutes or more of time outdoors

Additional Comments:

____

____

6. Conditions - General

	Current	Past
Headaches/Migraines		
Sleep Troubles, Fatigue		
Trauma (you may explain in the comment section below if you're comfortable)		
Fever		
Infection, Open Wound		
Lice		
Other		

Client Comments

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7. Conditions - Allergies & Sensitivities

	Current	Past
Scents, Oils, Lotions		
Detergents		
Fabrics		
Food		
Seasonal		
Sensitive Skin		
Other		

Client Comments

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8. Conditions - Muscles, Bones, & Joints

	Current	Past
Arthritis		
Osteoporosis		
Spinal or Disc Issues		
Fibromyalgia		
TMJ/Jaw Pain		
Spasms, Cramps		
Broken Bones		
Sprains, Strains		
Tendonitis, Bursitis		
Stiff or Painful Joints		
Weak or Sore Muscles		
Neck, Shoulder, or Arm Pain		
Low Back, Hip, Glute, or Leg Pain		
Other		

Client Comments

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9. Conditions - Skin

	Current	Past
Rashes		
Athlete's Foot		
Warts		
Abnormal Lumps		
Other		

Client Comments

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10. Conditions - Nervous System

	Current	Past
Head Injuries, Concussions		
Stroke		
Seizures/Epilepsy		
Dizziness, Fainting		
Ringing in Ears		
Memory Loss, Confusion		
Numbness, Tingling		
Shooting Pain, Sciatica		
Depression, Anxiety		
Other		

Client Comments

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11. Conditions - Endocrine System

	Current	Past
Glandular Issues		
Diabetes		
Other		

Client Comments

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12. Conditions - Digestive & Elimination

	Current	Past
Digestive/Constipation/Bowel Issues		
Gas, Bloating		
Bladder, Kidney, Prostate Issues		
Liver, Pancreas Issues		
Abdominal Pain		
Other		

Client Comments

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13. Conditions - Reproductive System

	Current	Past
Pregnancy		
Abnormal Menstruation		
Intense Cramping		
Other		

Client Comments

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14. Conditions - Respiratory & Cardiovascular

	Current	Past
COVID-19		
Heart Disease		
Heart Attack		
Pacemaker		
Blood Clots		
Stroke		
Lymphedema, Swelling		
High Blood Pressure		
Low Blood Pressure		
Irregular Heartbeat		
Circulation Issues		
Varicose Veins		
Chest Pain, Shortness of Breath		
Lung Disease		
Sinus Issues		
Tuberculosis		
Pneumonia		
Asthma		
Other		

Client Comments

15. Conditions - Immune System

	Current	Past
Chicken Pox, Shingles		
Mono		
Lupus		
Herpes Simplex		
Hepatitis		
HIV, AIDS		
Other		

Client Comments

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16. Conditions - Cancer/Tumors

	Current	Past
Benign Tumour		
Malignant Tumour		
Cancer, Chemotherapy		
Other		

Client Comments

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17. Conditions - Habits

	Current	Past	Frequency
Tobacco			
Alcohol			
Soda			
Marijuana			
Drugs			
Other			

Client Comments

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18. Additional Conditions & Comments

19. Appointment Information

Preferred Appointment Days & Times:

___

How did you hear about Kokoro Massage?

___

When was your last massage?

___

Any preference regarding pressure, music, temperature, etc.?

___

I, the client, promise that I have reported all health conditions and physical limitations to the best of my ability and comfort level and will inform my practitioner of any changes in my health. I understand that some conditions are contraindicated for massage and that the massage practitioner must be aware of any and all existing health conditions in order to provide appropriate treatment and care. I also understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder and does not perform joint or spinal manipulations or adjustments. I am responsible for consulting a qualified primary health care provider for any physical ailment that I may have.

___ Signature

___ Date