

CURA Holistic Health and Massage Center

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FeelHealed.com

MA 28362 / MM 14526



Confidential INTAKE Form

Name _____

Address _____

City _____ State _____ Zip _____

Phones: Home (____) _____, Work (____) _____, Mobile (____) _____

Occupation: _____

E-mail: _____ *May we send you monthly specials and updates: Yes No

Date of birth _____ Sex: M F Marital status: _____

Emergency contact: _____ Relationship: _____ Phone _____

Referred by: _____

Please list any surgeries in the last 5 years _____

Please list any medications currently using _____

Are you taking any nutritional supplements? Yes No If yes, please list: _____

List any allergies and reactions to these _____

Activities/Exercise: Never Light Moderate Heavy . **Are you pregnant:** Yes No **Due date:** _____

Reason for appointment (Major complaint) _____

Describe results from previous bodywork for this condition if any _____

Is there anything that makes the condition worse? _____

Please continue on reverse side →→→

Please "check mark" the following conditions that apply to you:

General:

- HEADACHES
- INSOMNIA
- DIZZINESS
- FAINTING SPELLS
- SEIZURES
- FATIGUE
- DEPRESSION
- ENLARGED THYROID
- BLURRED / DOUBLE VISION
- CRAMPS

- LOSS OF BALANCE
- EARS RINGING / POPPING
- CONTAGIOUS DISEASE
- CANCER (ANY TYPE)

Respiratory:

- SHORTNESS OF BREATH
- CHRONIC COUGH
- VOMITING BLOOD
- EMPHYSEMA
- BRONCHITIS
- ASTHMA (WEEZING)
- SINUSITIS
- TUBERCULOSIS

Skin:

- OPEN WOUNDS
- SKIN PROBLEMS
- BRUISE EASY
- DRYNESS
- FUNGUS
- ITCHING / BURN
- RASH
- CYSTS

Gastro intestinal:

- ABDOMINAL HERNIA
- COLITIS
- CONSTIPATION
- DIARRHEA
- CROHN'S DISEASE
- DIABETES
- HYPOGLYCEMIA
- ULCERATIVE COLITIS
- DIVERTICULITIS
- DIVERTICULOSIS

Muscle / Joint:

- ARTHRITIS
- BURSITIS
- BACK PAIN
- NECK PAIN
- SPRAINS

- SWOLEN JOINTS
- NUMBING LIMBS
- HERNIATED DISC
- BROKEN BONES
- SCIATICA PAIN
- ROTATOR CUFF PAIN
- JOINT REPLACEMENT
- OTHER _____

Cardiovascular:

- HEART PROBLEMS
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- COLD HANDS
- COLD FEET

- VARICOSE VEINS
- PHLEBITIS
- EDEMA
- STROKE
- ANGINA
- RAPID HEART BEAT
- IRREGULAR HEART BEAT
- C. N. G. HEART FAILURE

Genito-Urinary:

- HYSTERECTOMY
- KIDNEY INFECTION
- KIDNEY STONES
- KIDNEY FAILURE
- NEPHRITIS
- PAINFUL URINATION
- PROSTATE TROUBLE

Other (Please explain) _____

Please take a moment to carefully read this information:

If you have a specific medical condition or symptoms, massage may be CONTRAINDICATED. Referral from your primary care provider may be requested prior to treatment being provided. I understand the BENEFITS and RISKS of massage and give my consent for treatment. I have stated all medical conditions that I am aware of and will keep my practitioner informed of future changes. Therapist reserves the right to REFUSE or DISCONTINUE treatment according to contraindications, noncompliance with ethical codes, or sexual misconduct.

Date _____ Signature of Client/Patient _____