

MASSAGE THERAPY HEALTH INTAKE

Who Are You?

Today's Date _____

Name _____ Birthday _____

Address _____ City _____ Zip _____

Best Phone # _____ Email _____

Emergency Contact _____ Phone _____

Tell Me About Your Lifestyle

Area(s) of Tension _____

Do you exercise? _____ How often? _____

Type of exercise _____ Other Activities _____

Avg.# hours sleep /night 8 + 7 6 5 4 3 or less Do you wake during the night? Y N

Do you feel rested in the morning? Y N Are you often tired in the afternoon? Y N

Occupation/Primary Activities _____

How You Got Here

How did you hear about Neponset Valley Yoga?

Advertisement (where) _____ Mailer _____

Another Student (name) _____ Other _____

Would you like to receive emails from Neponset Valley Yoga?
(circle all that apply)

Weekly Sharing Newsletter

Upcoming Events No thanks

REGISTRATION AND HEALTH INTAKE FORM

Tell Me About Your Medical History – Current and Past

List any medications you are currently taking, including prescription, vitamins, herbs

General Signs and Symptoms **N** **Y** **Where**

| | | | |
|------------------------------------|---|---|--|
| Any swelling or tendency to swell? | N | Y | |
| Any sites of pain/tenderness? | | | |
| Any sites of numbness? | | | |
| Any sites of infection? | | | |

*If you have ever had any of the following please check **P** for “Past” or **C** for “Current”*

| | C | P | Medical Condition | | C | P | Medical Condition |
|--|---|---|----------------------------|--|---|---|---------------------------|
| | | | Addiction to drugs/alcohol | | | | Thyroid/Endocrine problem |
| | | | Hearing Loss | | | | Colitis |
| | | | Anxiety Disorder | | | | Urinary Disease |
| | | | Heart Trouble | | | | Diabetes |
| | | | HIV/AIDS | | | | Therapy/counseling |
| | | | Hernia | | | | Depression |
| | | | Allergies | | | | Tuberculosis |
| | | | Hypertension | | | | Digestive Problems |
| | | | Arthritis | | | | Eating Disorder |
| | | | Hypoglycemia | | | | Epilepsy |
| | | | Asthma | | | | Emphysema |
| | | | Orthopedic Problems | | | | Headaches |
| | | | Back Pain | | | | Glaucoma |
| | | | Respiratory Problems | | | | Gastritis/Ulcer |
| | | | Cancer | | | | PMS/Irregular Periods |
| | | | Sleep Disorders | | | | Menopausal Symptoms |
| | | | Candida | | | | Hot Flashes |
| | | | Suicidal thoughts | | | | Irritability |
| | | | Chronic fatigue Syndrome | | | | Mood Swings |
| | | | Surgery (recent) | | | | Other Health Issues |
| | | | Chronic Pain/Fibromyalgia | | | | |

I agree that all information provided is accurate and representative of my overall state of health and affirm that I am not under any restrictions by my doctor. I will inform Neponset Valley Yoga immediately in the event of a change in my health.

Signature _____ Date _____