Momentum Therapies
Health Intake Form

Name________________________________Date______________CurrentAge_______
Address____
Phone____________________Email___________________

Please complete the following information.
This will assist in designing the most effective and efficient individualized program for you.
Please check if you have a history of any of the following.

	Past	Present		Past	Present
High Blood Pressure			**Digestive Problems**		
Blood Clots			**Menstrual Problems**		
Varicose Veins			**Broken Bones**		
Heart Disease			**Whiplash**		
Chest Pain			**Headaches**		
Depression			**Chronic Pain**		
Anxiety			**Allergies**		
Insomnia			**Skin Problems**		
Cancer			**Fibromyalgia**		
Arthritis					

List any other medical conditions and medications you are taking.
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Please list below your main complaints/challenges in order of their importance.

1.____
2.____
3.____
4.____
5.____

I understand I am responsible for payment of all therapy provided by Momentum Therapies. I agree to make payment in full at time of session. I also understand I am responsible for payment of missed or canceled appointments with less than 24 hrs notice.
Signed____Date_______________