PATIENT INTAKE FORM

Grand Traverse Natural Health Care
626 East Eight Street, Suite 17
Traverse City, Michigan 49686
phone 231.929.8183
www.gtnaturalhealth.com clinic@gtnaturalhealth.com

Today's Date _____

Name _____ Date of Birth _____

Address _____ City, State, Zip_____

Phone (H) _____ (M) _____ (W) _____

Email _____

Primary Physician _____

Emergency Contact _____ Phone _____

Occupation_____

How would you like us to contact you for follow-up questions, appointment confirmations or responding to messages? ❍ Home phone ❍ Mobile phone ❍ Work Phone

May we leave messages on your phone voicemail? ❍ Yes ❍ No

How did you hear about us? Doctor _____ Name of Friend _____

❍ Phone book ❍ Article in Media ❍ Clinic Sign ❍ Internet

Have you received a professional massage or bodywork session in the past? ❍ Yes ❍ No

If yes, was your experience pleasant? ❍ Yes ❍ No If not, why?_____

If yes, what was the date of your last session? _____

What is your pressure preference? ❍ Light ❍ Medium ❍ Deep ❍ Integrative

What are your common areas of pain or tension? _____

Please list any areas of your body to be avoided: _____

Do you have any allergies or are you sensitive to fragrances? _____

Please list any medications and/or supplements you are currently taking: _____

_____

Please indicate any of the following that apply to you now or in the past:

- ❍ Headaches, migraines
- ❍ Neck/back injuries
- ❍ High/low blood pressure
- ❍ Cancer, tumors
- ❍ TMJ/jaw problems
- ❍ Numbness
- ❍ Spider/varicose veins
- ❍ Heart/circulation problems
- ❍ Contacts
- ❍ Dentures
- ❍ Arthritis
- ❍ Major accident
- ❍ Hemorroids
- ❍ Recent injuries
- ❍ Blood clots/fresh bruises
- ❍ Pregnancy, or trying to get pregnant
- ❍ Surgeries
- ❍ Recent eye procedures
- ❍ Implants
- ❍ Diabetes
- ❍ Abnormal skin conditions
- ❍ Fibromyalgia

Explain any of the conditions that you have marked above or other concerns: _____

_____

If pregnant, please answer the following questions:
Due date _____

Have you been pregnant before ❍ Yes ❍ No
How would you describe this pregnancy? _____
Please check any of the following that apply to this pregnancy, as a physician's release may be required for massage: ❍ High-risk (i.e. twins, history of miscarriage)

❍ Pre-eclampsia ❍ Gestational diabetes ❍ Deep vein thrombosis

Do you have any issues related to this pregnancy that would like special attention? __

_____

I understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Care Provider for any condition that I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. Due to certain contraindications and cautions for massage, the massage practitioner must be aware of existing physical and mental conditions. I have informed the massge therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Signature_____Date_____
If under 18, signature of parent or guardian_____