Sacred Roots

Client Intake and Health History

Name _____ D.O.B. _____

Address _____ City, State & Zip code _____

Home Phone _____ Cell Phone _____ E-Mail _____

Occupation _____ Physician _____ Referred by _____

Is this your first massage/healing? _____ Reason for appointment today _____

* Please mark an X on all conditions you are currently experiencing and a P for past conditions*

_____ **Chronic Pain**	_____ **Whiplash**	_____ **Shortness of Breath**
_____ **Muscle or Joint Pain**	_____ **Osteoarthritis**	_____ **Heart/Circulatory Issues**
_____ **Muscle or Joint Injury**	_____ **Rheumatoid Arthritis**	_____ **High/Low Blood Pressure**
_____ **Numbness/Tingling**	_____ **Osteoporosis, Osteopenia**	_____ **Diabetes**
_____ **Spinal Column Disorder**	_____ **Hernia**	_____ **Seizures**
_____ **Sciatic Pain**	_____ **Fatigue**	_____ **Blood Clots**
_____ **Tendonitis**	_____ **Stress/Tension**	_____ **Emphysema**
_____ **Sprains/Strains**	_____ **Sleep Difficulties**	_____ **Abdominal or Digestive Issues**
_____ **Headaches/Migraines**	_____ **Brain/Head Injury**	_____ **Anxiety/Depression**
_____ **Jaw Pain/TMJ**	_____ **Hearing Loss/Deafness**	_____ **Varicose Veins**
_____ **Broken Bones**	_____ **Asthma/Lung Conditions**	_____ **Rash/Athletes Foot**
_____ **Carpal Tunnel**	_____ **Cancer/Tumors**	_____ **Pregnancy If Y, Due Date** _____

Do any of these conditions interfere with your daily activities? Please explain _____

_____

Are there any other conditions not listed (fever, infections, etc)? _____

Please list and date all surgeries _____

_____

Current Medications _____

Stress Reducing Activities/Hobbies _____

Is there any place that you DO NOT want worked on? _____

This information and our sessions together are confidential. Communication between you and I is very important so please feel free to give me feedback at any time, during or after the massage.

Signature _____ Date _____