recentermassage@gmail.com
www.recentermassage.com
206-714-9751
Philadelphia, PA

Health History Intake

Personal Information

Date _____

First Name _____ Last Name _____

Gender Preference/Pronouns (circle one): He/Him She/Her Other_____

Date of Birth (mm/dd/yyyy)_____ Phone _____

Address:

_____

City _____ State _____ Zip/Postal _____

Email _____

How did you hear about Recenter Massage?

Emergency Contact

Name _____ Phone _____

Relationship to You: _____

Additional Contact Info

_____

Health Information

Reason(s) for visit/ Main Concerns:

_____

_____

_____

Current Symptoms (ie swelling, heat, limited range of motion, difficulty gripping etc)

_____

_____

_____

_____

How would you describe your concerns today? (circle any/all that apply)

Pain Ache/Sore Stiff Sharp/Stabbing Pins & Needles Numb Dull Throbbing Bruised Tight Dizziness Headache Migraine Sprain/Strain Fracture Anxiety

List all past surgeries/operations and include dates if possible (this includes deliveries, teeth work or cosmetic surgeries).

_____

_____

_____

List any/all Medications you are currently taking...

*Please note, if you are taking **pain killers** or **muscle relaxers** for any reason it is **essential** to let your therapist know as it could result in more pain or injury post session if your sense of touch is being affected by the medication.

_____ _____

_____ _____

_____ _____

_____ _____

Do you currently or have you in the past experienced any of the following:

General

- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Concussion
- ❑ Congestion
- ❑ Insomnia
- ❑ Anxiety

Respiratory

- ❑ Difficulty Breathing
- ❑ Sinus issues
- ❑ Circulatory Issues
- ❑ Ongoing Cough

Endocrine

- ❑ Stomach aches
- ❑ Indigestion
- ❑ Cramping
- ❑ Irritable bowels

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Diabetes
- ❑ Stroke
- ❑ Heart attack
- ❑ Heart Murmurs
- ❑ Blood clotting

Musculoskeletal

- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Autoimmune disorder
- ❑ Lupus
- ❑ Schleroderma
- ❑ Dislocation
- ❑ Other:_____ _____

Any additional information that is relevant for your massage therapist to know:

_____
_____
_____
_____

Consent and Policy Agreement

Client Agreement

_____ It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Practice Policies

_____ I am responsible for all charges for all services provided. I understand that if I give less than 24 hours notice to cancel my appointment, I am responsible to pay the cancelation fee up to the full amount of the session. I understand that at this time, my massage therapist, Meredith Holladay, LMP and the entity ReCenter Massage and Bodywork LLC, does not bill insurance.

Contract for Care

_____ I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised during the session. I expect my practitioner to provide safe and effective treatment to the best of her skills and knowledge.

_____

Client Full Name (Print)

_____ date _____

Client Signature

_____ date_____

Guardian Signature