Fine Tune Health Care Intake Form

Name _____ Date _____

Address _____ Phone _____

City _____ State _____ Zip_____ Cell _____

DOB _____ Age _____ Sex: ____ Email _____

Emergency contact name _____ Phone _____

EC Relationship to you _____ Referred by _____

Primary Health Care Provider _____ Phone _____

What brings you here today? _____

_____

_____

Explain any medical treatment you are currently receiving _____

_____

_____

Explain any medications or supplements you are taking _____

_____

_____

Any Allergies? _____

Please check and explain your experience with any of the following:

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ TMJ dysfunction
- ☐ Strains, sprains
- ☐ Tendonitis
- ☐ Carpal tunnel synd.
- ☐ Thoracic outlet synd.
- ☐ Cramping, spasms
- ☐ Soreness
- ☐ Limit Range of Motion

Lymph and Immune
- ☐ Edema
- ☐ Hodgkin's disease
- ☐ AIDS, HIV
- ☐ Chronic fatigue synd.
- ☐ Lupus

Nervous System
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ Post polio syndrome
- ☐ Headaches/Migraines
- ☐ Stroke
- ☐ Seizure disorders
- ☐ Reduced Sensations
- ☐ Mental health

Integumentary
- ☐ Boils /Cysts
- ☐ Fungal Infections
- ☐ Herpes simplex
- ☐ Warts
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Allergies

Digestive
- ☐ Cirrhosis
- ☐ Ulcerative colitis
- ☐ Diverticulosis
- ☐ Gallstones
- ☐ Hepatitis
- ☐ IBS/ Crohns Disease
- ☐ Ulcers

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Tuberculosis

Addictive Substances
- ☐ Caffeine
- ☐ Alcohol
- ☐ Tobacco
- ☐ Other Drugs

Circulatory
- ☐ Anemia
- ☐ Thrombophlebitis
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Diabetes
- ☐ PAD
- ☐ Restless Leg Synd.

Urinary/Reproductive
- ☐ Currently pregnant
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful menstruation
- ☐ Kidney stones
- ☐ STD's
- ☐ BPH. Prostrate cancer

Explain any of the conditions above or any not yet identified _____

_____

_____

_____

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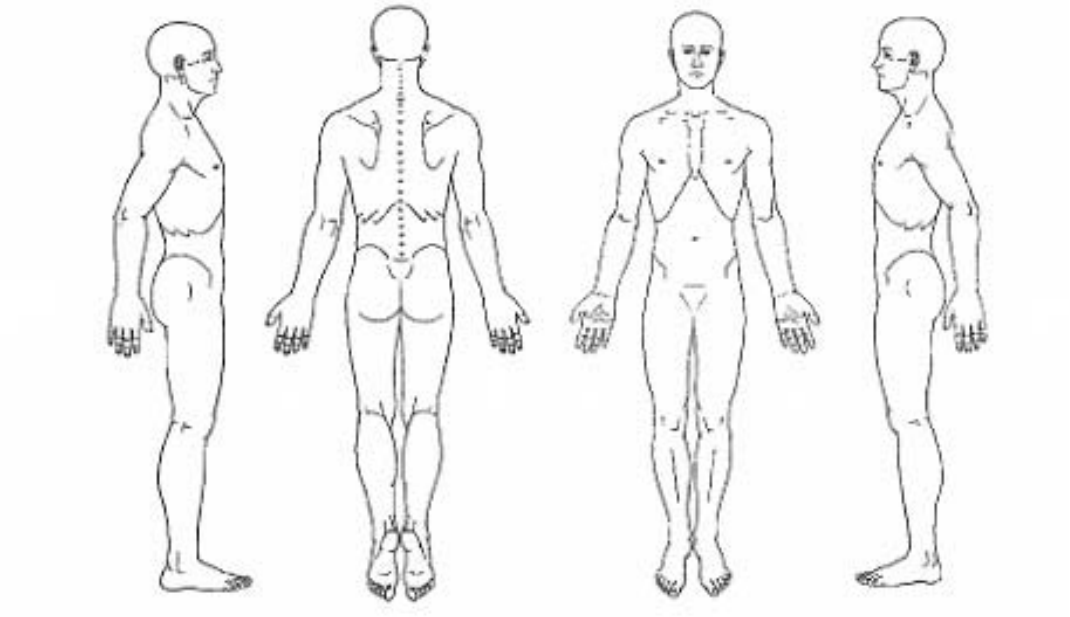
Place an "X" over problem areas



If you are experiencing pain or discomfort – please rate on a scale of 1-10.

Today:	(no pain) 0	1	2	3	4	5	6	7	8	9	10 (worst pain imaginable)
Typical day:	(no pain) 0	1	2	3	4	5	6	7	8	9	10 (worst pain imaginable)

What do you do for relief? _____

Do you exercise? _____

Informed Consent and Body Work Policies

☐ I understand that body work is not a substitute for medical examination or diagnosis, and that I should see a Licensed Health Care Provider to diagnose any medical concerns. I understand that my practitioner has been trained in various medical massage techniques and is licensed as a Licensed Massage Therapist (LMT) in the state of Ohio.

☐ I am aware that body work is contraindicated for some medical conditions and I affirm that I have answered all questions truthfully to the best of my knowledge, and agree to update the practitioner on any changes in my health status and medical history. I agree to inform the practitioner of any pain experienced during the initial and subsequent sessions, and furthermore understand that I have the right to refuse any treatment or ask that it be modified in regard to pressure or technique.

☐ I understand that all written records and sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical providers without explicit written consent from the client or the client's legal guardian unless legally required by local, state, or federal subpoena, summons, or court order.

_____ _____

Signature Date