Confidential Health Intake Form

Ohana Wellness
4815 St. Elmo Avenue (2nd Floor)
Bethesda, MD 20814
ohanawellnessbethesda.com
(301) 215-6388

Name: _____ Date of Birth: _____ Today's Date: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Work Phone: _____ Home phone: _____ Cell Phone/pager: _____

Email address: _____

Emergency Contact: _____

Occupation/employer: _____

Who referred you: _____ Primary Care Physician: _____

Reason for Appointment: ___ Stress Relief ___ *Accident/Injury ___ Gift Certificate
___ Sports Enhancement (training/rehab) ___ Other

*Was injury a result of an accident? _____ If yes: job related:_____ auto:_____ other:_____

Date of injury or onset: _____ If applicable, briefly describe the events which caused your pain/injury/accident: _____

_____

Have you received therapeutic massage before? _____

What do you want to get out of your session(s)? _____

List any areas for your therapist to AVOID (i.e. hair/face/bruises/injuries): _____

_____

Medical History and Information: ***(****Check any or all that apply to your present health.)***

___ headaches	___ chronic pain	___ varicose veins
___ vision problems	___ muscle or joint pain	___ blood clots
___ sinus problems	___ numbness/tingling	___ high/low blood pressure
___ jaw pain/teeth grinding	___ sprains/strains	___ diabetes
___ fatigue	___ scoliosis	___ cancer/tumors
___ depression	___ arthritis	___ infectious disease
___ sleep difficulties	___ tendonitis	___ skin problems

Other: _____ (OVER)

Medical History (*cont'd.*)

Women: ___ Pregnant ___ Painful menstruation ___ Endometriosis

Men: ___ Prostate problems

List all current medications: ______________________________

List all allergies (medications/**lotions/oils/scents/aromatherapy**): ______________________________

List previous major injuries/surgeries within the last 3 years: ______________________________

Exercise:

List physical activities you participate in regularly: ______________________________

What movements or activities are limited? ______________________________

If you are seeking massage for pain relief, what seems to help reduce the pain the most? ______________________________

What seems to aggravate the condition the most? ______________________________

What is your main activity at work and/or during the day? ___ On phone ___ Sitting ___ Computer work ___ Driving ___ Walking ___ Other*

(*Please describe) ______________________________

What do you do to relieve stress? ______________________________

What other treatments are you receiving or have you recently received and by whom? (Acupuncture, physical therapy, chiropractic, naturopathic, etc.): ______________________________

<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I agree to provide a **24-hour cancellation notice**. If I fail to do so, I agree to pay the full appointment fee. I am aware that this practitioner does not participate with my insurance plan and that I am responsible for payment at the time service is rendered. **Ohana accepts cash, check, credit cards and PayPal for payments.**

Please take a moment AFTER your first session to fill out our NEW CLIENT SURVEY. A link to our survey is located on our homepage, www.ohanawellnessbethesda.com. Your feedback will remain private and confidential. Thank you!

Signature: ______________________________ Date: ______________________________

<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

Practitioner's Name: ______________________________ Practitioner Comments: ______________________________