Sage Health & Wellness

4021 Vernon Ave S. Suite #210
St. Louis Park, Mn 55416
612-486-2612

Client Health History Intake

Please take a moment to answer the following questions. The information you provide will be used to customize your session.

Name _____Date of Birth_____ Gender_____
Address_____ City / State / Zip_____
Phone _____ Email _____
Occupation_____ Referred By / How did you Find Me _____
Physician _____Other Healthcare provider _____

Receive appointment reminders (Please Circle) Text Email NONE
Current Medications / Supplements_____
_____

Do you have any allergic reactions to oils, lotions ? YES / NO
Do you have any particular goals for today's session _____
_____
_____

Do you have any known history of trauma whether physical or emotional? YES / NO
What do you do to help manage your stress ? _____

Have you ever worked with a life coach ? YES / NO

Health History
Please check if you have a history of any of the following:

_____ High / Low Blood Pressure
_____ Blood Clots
_____ Diabetes
_____ Immune System Disorder
_____ Dizziness / Vertigo
_____ Cancer _____

_____Neuropathy / Numbness / Tingling
_____Sensitive to pressure (Bruising, soreness)
_____ Anxiety / Depression/Mental health issues
_____Headaches / Migraines
_____ Respiratory Conditions
_____ _____

Please provide any further details or treatment for conditions marked above:
_____
_____

Please check if you have had any of the following, or are currently having:

_____ Head / Neck / Jaw / TMJ
_____ Neck / Shoulder Pain
_____ Carpal Tunnel
_____ Back / Low Back Pain
_____ Hip / Sciatic Pain
_____ Knee Issues
_____ Plantar Fasciitis
_____ Tendinosis / Tendinitis
_____ Leg / Knee / Foot

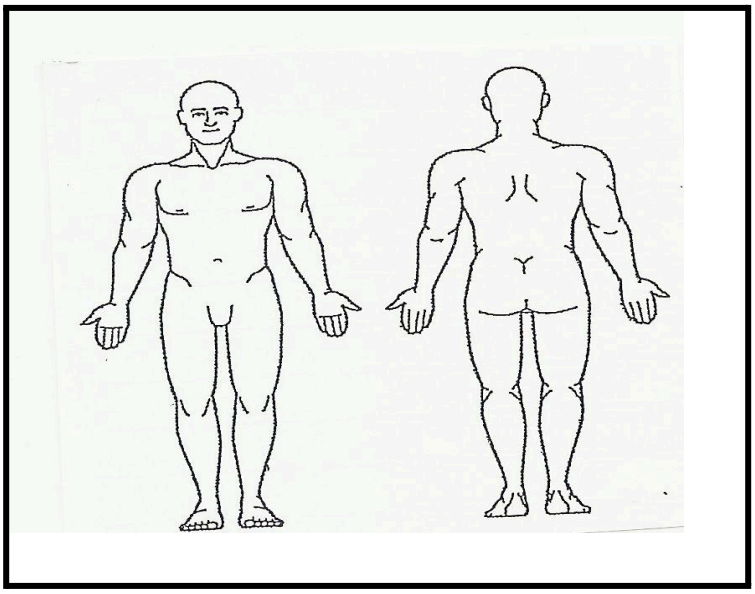
(**OVER**)

Please list any accidents or surgeries and dates :

_____

_____

Circle or mark the body part you are experiencing tension,
Stiffness or other sensation.



Health History information / agreement:

The above information is accurate and true to the best of my knowledge. I am aware that I need to update my massage therapist about any new medical conditions as it may affect my massage session.

I understand that my personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA) Any information collected by Human Touch Massage is for the purpose of providing treatment to me, collecting payment for service rendered to me, and for general Human Touch Massage administrative operations.

I agree that I was offered a copy of Human Touch Massage Privacy Policies _____Initals

Payment and Cancellation Policy

Payment is due at the time of treatment. I accept cash, check or credit card payment. I request that if you need to cancel, I require 24 hour notice. This is to make that appointment time available to other clients. If you cancel your appointment less than 24 hours, full payment is required before making another appointment unless payment arrangements are made with Human Touch Massage.

Informed Consent

I understand that massage therapy is for the purpose of stress reductions, relief from muscle tension or muscle spasms and increasing circulation.
Massages therapy / body work should not be performed if I have certain medical conditions.

If I experience any pain or discomfort during the sessions, I will inform the practitioner so that the pressure and strokes may be adjusted to my comfort level.

I understand that massage therapists may not diagnose, prescribe or treat any physical or mental illness and that anything in the session may not be considered as such.

Client Signature _____ Date _____

(**OVER**)