# Adirondack Salt Cave Health History Intake Form

**Confidential Information**

**Name:** _____ **Date of Birth:** ____/____/___

Have you received massage therapy before? Yes ___No___

What type of pressure do you prefer? Light ___Moderate ___Deep ___Not sure___

What is your occupation? _____

What are the expectations/goals for this massage session? _____

Have you had any current surgeries? _____ (within the last 2 years)

Explain: _____

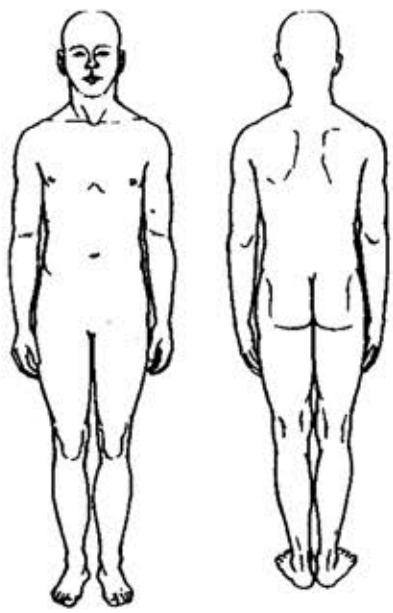
Do you have any allergies to oils or lotions? _____sensitive skin (y/n)? _____

Are you pregnant? _____how many weeks? _____

**Do you have any of the following (circle)**

| | | |
|---|---|---|
| Abdominal Pain | Fibromyalgia | Anemia |
| Accident | Headaches | Jaw Pain/TMJ |
| Allergies | Heart Disease | Multiple Sclerosis |
| Arthritis | High Blood Pressure | Osteoporosis |
| Bursitis | HIV | Pacemaker |
| Gout | Joint Pain | Parkinson's Disease |
| Broken Bones | Lower Back Pain | Hernia |
| Blood Clots | Mid Back Pain | Glaucoma |
| Cancer | Nervous Tension | Hypertension |
| Colitis | Sprains/Strains | Bronchitis |
| Diabetes | Stroke/Seizures | Pinched Nerve |
| Disc problems | Varicose Veins | Prosthesis |
| Sinus Problems | Tendonitis | Thyroid Issues |
| Tumors or Growths | Ulcers | Whiplash |

Please indicate areas you feel discomfort or need



Medications: _____

_____

Primary Physician: _____Phone #:_____

Emergency Contact: _____Phone #:_____

**PLEASE READ AND SIGN BELOW:**

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I will inform my therapist of any changes in my health or medications prior to each session.
- I am responsible for paying for any missed appointment or cancellation less than 24 hours.

**Signature:** _____**Date:**_____