FUNCTIONAL SPORTS THERAPY AND FITNESS
Your Path to Better Performance

Health Intake Form

Jake Norman, LMT, ART, Lic # MT112976
4111 Marathon Blvd. Austin, TX 78756

Name: _____Date: _____/_____/_____
Address: _____City_____ Zip:_____
Telephone Number - Day: _____-_____ Evening: ____-_____ Cell: _____-_____-_____
Email: _____DOB:____/____/____ Sex: M____F____
Occupation/Duties: _____ Referred by: _____
In Case of Emergency: _____ Phone :(___) _____
May we add your email to provide you with updates/health/wellness information? (Y / N)
Please list your primary areas of discomfort, pain or tension:

_____
_____
_____

Are there certain activities that aggravate this condition?

_____
_____

Onset of discomfort/tension**:** ◯ Sudden ◯ Gradual
Duration of discomfort/tension: _____Hours _____Days _____Weeks _____Months _____Years
Frequency of discomfort/tension: ◯ Seldom ◯ Intermittent ◯ Frequent ◯ Constant

What describes the nature of your symptoms:
☐ Sharp ☐ Dull ☐ Dull Ache ☐ Tingling ☐ Burning ☐ Shooting

Severity of discomfort/tension:
◯ Mild ◯ Moderate ◉ Severe
On a scale of 1-10, rate the level of pain you are experiencing today: _____

Do you suffer from Headaches
Headaches: ◉ **YES** ◯ **NO**
Frequency? ◯ Daily ◯ Weekly ◯ Monthly ◉ Occasionally Other: _____

Medical Health: ◯ ◉
Are you currently under a physician's care for your visit today? Yes or No, if yes, who are you seeing?_____ _____
Are you taking any medications? Y/N If yes, please list:

_____

Exercise:
Exercise amount per week and types of exercise:

_____
_____

Please check any conditions that apply to you, either NOW or in the PAST:

☑ Allergies ☑ Contagious Disease ☐ Skin Problems ☑ Arthritis
☐ Spinal Problems ☑ Carpal Tunnel Syndrome ☑ Varicose Veins ☑ STD
☐ Joint Problems ☑ Circulatory Problems ☑ Blood Clots ☑ Dizziness
☑ Diabetes ☑ Muscular Injuries ☑ Depression ☑ Fibromyalgia

Have you ever been diagnosed with any of the following conditions?

☑ Arthritis – Type and Locations: _____
☑ High blood pressure ☑ Low blood pressure
☑ Aneurism ☑ Embolism ☑ Other blood Dx _____
☑ Heart Disease Dx_____
☑ Diabetes: ☑ Type I ☑ Type II [Adult Onset] ☑ Other: Dx_____
☑ Cancer – Type and Location: _____
☑ Spinal Condition : ☑ Scoliosis ☑ Osteoporosis ☑ Other: _____
Other Medical Conditions: _____
Have you had any recent injuries? ☐ Work related ☐ Motor Vehicle Accident ☐ Other
If Other, Please List: _____
Have you ever had surgery? Y/N (Affected area of body) _____
Date/Year: _____

I understand that: massage therapy involves neither diagnosis nor treatment of any condition, and is not a substitute for medical care; should this session contain Swedish, deep, or sports massage, appropriate draping will be applied to all areas except the area being worked; neither my breasts (female) nor genital areas will be massaged; I may itemize here any areas of my body which I wish to be avoided, and these will be avoided (Itemize here if relevant:_____); if I am uncomfortable for any reason I may request the therapist to end the session, and the session will be ended.

I have stated all my known medical conditions and take it upon my self to keep the massage therapist updated on my physical health.

I hereby authorize the release of medical information necessary to other doctors and insurance companies. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

_____ _____/_____/_____

Client or guardian Signature Date