# Patient Health Intake Form

## General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No   May we contact you via email? ☐ Yes ☐ No

Would you like to be added to our email list? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

## Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ ___________

Spouse/Partner

## Employment

Employer | Occupation

Please check all that apply:

☐ Disabled ☐ Employed Part Time ☐ Unemployed
☐ Employed Full Time ☐ Retired ☐ Student

## Medical History

Please check all that apply:

☐ Aortic Aneurysm
☐ Anxiety
☐ Arnold-Chiari Malfomation
☐ Autoimmune Disorders
☐ Blood Clot Disorders
☐ Cancer
☐ COPD
☐ Depression

☐ Diabetes Type 1 or II
☐ Ehlers-Danlos Syndrome
☐ Fibromyalgia
☐ Headaches/Migraines
☐ Heart Disease
☐ Hepatitis B/C
☐ HIV
☐ Hypertension

☐ Lupus
☐ Lymphedema
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Seizures
☐ Stroke
☐ Thyroid Disease

## Medical History Continued

Surgical History: ____________________________________________

____________________________________________

____________________________________________

Do you have any Implants? ☐ Silicone ☐ Pacemaker ☐ Injectable Fillers ☐ Hardware ☐ Spinal Stimulator

If yes, please explain location: ____________________________________________

____________________________________________

What medications are you on?

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Have you ever had Physical Therapy before? ☐ Yes ☐ No Did you have a positive experience? ☐ Yes ☐ No

Have you ever had Massage Therapy before? ☐ Yes ☐ No Did you have a positive experience? ☐ Yes ☐ No