



Vickii Engel Thomas

Holistic Massage &  
Integrative Bodywork

## HEALTH INTAKE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Experience with body work:

- \_\_\_\_\_ Massage
- \_\_\_\_\_ Physical Therapy
- \_\_\_\_\_ Acupuncture
- \_\_\_\_\_ Chiropractics
- \_\_\_\_\_ Energy Work
- \_\_\_\_\_ Other: \_\_\_\_\_

**MEDICAL HISTORY:** *(Check any of the following you have had)*

- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Sinus Problems
- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Shoulder Pain
- \_\_\_\_\_ Heart Problems
- \_\_\_\_\_ High/Low Blood Pressure
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Immune Disorders
- \_\_\_\_\_ Circulatory Problems
- \_\_\_\_\_ Blood Clotting
- \_\_\_\_\_ Varicose Veins
- \_\_\_\_\_ Phlebitis
- \_\_\_\_\_ Skin Conditions
- \_\_\_\_\_ Low Back Problems
- \_\_\_\_\_ Broken Bones
- \_\_\_\_\_ Sprains
- \_\_\_\_\_ Contact Lenses
- \_\_\_\_\_ Recurring Symptoms

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

Physician: \_\_\_\_\_

Are you currently under a doctor's or therapist's care? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Due date: \_\_\_\_\_

## LIFESTYLE & BODY AWARENESS

What kind of movement does your body do in the course of a day? \_\_\_\_\_  
\_\_\_\_\_

What exercise does your body receive? \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your dietary habits. \_\_\_\_\_  
\_\_\_\_\_

What is your intake of the following:

Coffee \_\_\_\_\_

Cigarettes \_\_\_\_\_

Alcohol \_\_\_\_\_

Soft Drinks \_\_\_\_\_

Artificial Sweeteners \_\_\_\_\_

Sugar/Chocolate \_\_\_\_\_

Dairy Products \_\_\_\_\_

Water \_\_\_\_\_

Nutritional Supplements \_\_\_\_\_

Are you under stress? \_\_\_\_\_ Source? \_\_\_\_\_  
\_\_\_\_\_

Where in your body are you aware of stress or discomfort? \_\_\_\_\_  
\_\_\_\_\_

Has your body suffered any insults or trauma? *(Please describe)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you do for relaxation or self care? \_\_\_\_\_

What is nurturing or nourishing for you? \_\_\_\_\_

What emotions are you **most** comfortable expressing? Where in your body do you experience or hold it? \_\_\_\_\_

What emotions are you **least** comfortable expressing? Where in your body do you experience it or hold it? \_\_\_\_\_

I hereby give my consent to receive a massage. I understand that massage therapists are not physicians and that I am not here for medical, diagnostic or treatment procedure.

I agree to keep the therapist informed of any medical problems that occur during the time period of our work together. I also agree to give 24 hours notice should I need to cancel or reschedule my appointment.

Signature: \_\_\_\_\_

THANK YOU!