

Alpenglow Massage Intake Form

Name: _____

Date: _____

Date of Birth: _____

Gender: M F

Why have you come for a massage? _____

Have you received massage before? Yes No

Describe any accidents, injuries or surgeries:

Less than 5 years ago: _____

More than 5 years ago: _____

Are you currently receiving any medical treatment? _____

Please list any medications you are taking: _____

Please check if you are currently experiencing any of the following?

Pregnancy Flu or Cold Contagious Disease Inflammation Fever Infection

Injury Rash or Skin Condition:

If so, where? _____

HABITS

Exercise? _____

Sleep Difficulties? Yes No Please describe: _____

Where do you tend to hold stress in your body? _____

Where do you have any especially tender-to-touch areas? _____

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Please check if you have ever experienced any of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stiff Joints |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Strains |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Swollen Feet |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraines | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Swollen Legs |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> No Periods | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Excess Stress | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fracture | <input type="checkbox"/> PMS | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Gout | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rashes | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ringworm | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Schizophrenia | |
| | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sciatica | |

Please read and sign the following:

I acknowledge that the above information is complete and accurate to the best of my knowledge.

Patient Signature _____ Date _____

Therapist Notes _____

Therapist Signature _____

Date: _____

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