Hudson Holistics Confidential Intake Form

Today's Date_____ Email:_____

Name:_____ Phone:_____

Address:_____

_____DOB:_____

Height:_____Weight:_____

How did you hear about me?_____

Medical Information:

Please check off any current conditions or conditions experienced in the recent past

☐ Arthritis	☐ Fibromyalgia	☐ Pregnant
☐ Auto Immune	☐ Headaches	☐ Reduced Motion Range
☐ Blood clots	☐ Heart Condition	☐ Sciatica
☐ Bruise easily	☐ Herniated Disk(s)	☐ Scoliosis
☐ Cancer	☐ Inflammation/Edema	☐ Severe Cuts
☐ Chemotherapy	☐ Insomnia	☐ Skin Condition(s)
☐ Chronic pain	☐ Muscle strain/sprain	☐ Spinal fusion
☐ Constipation	☐ Numbness	☐ TMJ Syndrome
☐ Contagious disease	☐ Paralysis/spasticity	☐ Varicose Veins
☐ Depression	☐ Pinched Nerve	☐ Whiplash

Other Conditions / Allergies?_____

Current medications taken?_____

Primary goals for today's session?_____

Have you ever received professional massage __Y ___N When? _____

Massage Pressure Preferred?_____

Activities:_____

Doctor & Address:_____