Mantra Wellness Health History Intake
Confidential Information

9 Corporate Drive, Suite 3
Clifton Park, NY 12065

Name: _____ Date of Birth: _____
Address:_____
Phone: _____ Email:_____
Emergency Contact: _____ Phone: _____
Occupation? _____ How did you hear of us? _____

Have you ever received massage therapy before? Yes ____ No ____ Type? _____

What type of pressure do you prefer? Light ____ Moderate ____ Deep ____ Not Sure _____

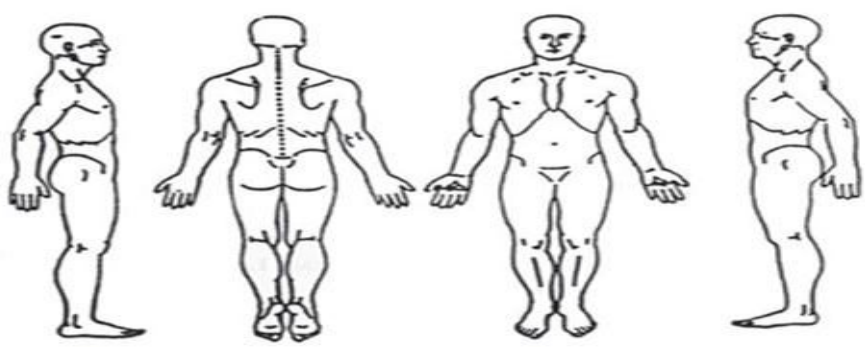
What do you hope to accomplish from today's massage? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had ie: Neck or back Surgery, Lymph node removal, etc)
Explain: _____
Date of injury: _____ Date unable to work: _____ Dates hospitalized: _____

Is there any chance you might be pregnant? Yes ___ No ____ 1st ____ 2nd ____ 3rd ____ trimester

Are you aware of any tension holding spots in your body? ____ If yes, location(s)
_____

Please indicate areas you feel discomfort or need attention:



Please list any medications (vitamins, herbs, or pharmaceutical) taken now or at regular intervals:

Medications:	Reason:
_____	_____
_____	_____
_____	_____

COVID-19 DAY OF APPOINTMENT SCREEN:

Have you traveled outside the US in the last 14 days? _____
Have you ever tested positive for Covid-19? _____
Do you have any Flu or Cold symptoms?_____
Temp: _____ O2: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

____Inflammation ____Fever ____Infection ____Contagious Disease ____ Allergies _____

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MUSCULOSKELETAL
__ Fibromyalgia
__ Spasms/cramps
__ Sprains/strains
__ Osteoporosis
__ Postural Deviation
__ Gout
__ Osteoarthritis/Rheumatoid arthritis
__ TMJ
__ Cysts
__ Bursitis
__ Plantar Fasciitis
__ Tendonitis
__ Torticollis
__ Whiplash Syndrome
__ Carpal Tunnel Syndrome
__ Sciatica
__ Thoracic Outlet Syndrome
__ Headache
__ Arm/shoulder pain
__ Neck pain
__ Mid Back pain
__ Low Back pain
__ Hip or Leg pain
__ Other _____

RESPIRATORY
__ Pneumonia
__ Sinusitis
__ Asthma
__ Trouble breathing
__ Dizziness
__ Other _____

CIRCULATORY
__ Anemia
__ Hemophilia
__ PAD
__ Low Blood Pressure
__ High Blood Pressure
__ Varicose Veins
__ Heart Condition
__ Blood Clots/Phlebitis
__ Diabetes
__ Raynaud's Disease

DIGESTIVE
__ Ulcers
__ Irritable Bowel Syndrome
__ Colitis
__ Gallstones
__ Hepatitis
__ Crohn's Disease
__ Diarrhea
__ Gas/bloating
__ Indigestion
__ Other _____

SKIN
__ Fungal Infection
__ Acne
__ Impetigo
__ Dermatitis/Eczema
__ Psoriasis
__ Open wound/sore
__ Rashes
__ Warts/Moles
__ Athlete's Foot
__ Other _____

NERVOUS SYSTEM
__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuritis
__ Spinal cord injury
__ Stroke
__ Trigeminal Neuralgia
__ Seizure Disorder
__ Numbness/Tingling
__ Lupus

OTHER
__ Insomnia
__ Anxiety/Panic Attacks
__ PMS
__ Grief Process
__ Traumatic Event
__ Substance Abuse
__ Lyme Disease
__ Chronic Fatigue
__ HIV/AIDS
__ Hep B/C
__ Kidney Disease
__ Bladder Infection
__ Postoperative
__ Edema

CANCER
Type: _____
Location: _____
Stage: _____
Chemo: _____
Radiation:_____
Lymph Nodes _____

(Only Complete If Using Insurance)
Medical Insurance:
Insurance Carrier: _____
Insurance ID: _____ **Group#:**_____
Primary Card Holder: _____ **DOB:** _____

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage or bodywork from this practitioner. I also understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health including Covid-19. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies/Covid-19 excluded) may be charged in full for the price of the missed session.

Signature: _____ **Date:** _____
Parent or Guardian Signature if under 18 yrs old