Mohawk Valley Healing Therapies

87 Utica St.
Clinton, NY 13323

6128 McLaughlin Rd.
Oriskany Falls, NY 13425

Intake Form

Name: _____

Address: _____

_____

Phone: Cell _____ Home: _____

Birth date: _____ (necessary for record retention)

E-mail (for office updates) _____

Occupation (Current or retired from):_____

Emergency Contact: _____ Phone: _____

Physician Name: _____ Phone: _____

Chiropractor Name: _____ Phone: _____

Have you had a professional massage before? Yes ____ No ____

How did you learn about MV Healing Therapies? (If from a friend, please provide name so they can receive credit for the referral) _____

What results are you looking for from working with me (try to be specific)?_____

_____

Medical Information

List ALL accidents, hospitalizations and surgeries (provide the year): Any lingering effects?

Any chronic, or ongoing pain? No ____ Yes ____ If yes, please describe.

Do any activities affect the pain? Please describe.

The following helps determine my treatment options:

Are you taking any medications and why?

History: (please circle) If more room is required, please ask for a separate sheet of paper.

Muscles/Skeleton:
Osteoporosis/
Osteopenia
Arthritis / Stenosis
Fibromyalgia
Bursitis / Tendonitis
Soreness
Plantar fasciitis
TMJD
Chronic headaches
Migraines
Whiplash
Herniated Disc
Strains/Sprains
Orthopedic pins/plates
Scoliosis
Ehlers-Danlos

Pain in:
Neck
Shoulder
Arm / Elbow
Wrist/hand
Hip
Leg
Back:
Upper / Middle / Lower

Other
_____

_____

Respiratory:
Pneumonia
Asthma
Breathing Problems
Sinusitis
Cold/Flu
COVID
Allergies
_____

_____

Other
_____

_____

Digestive:
Colitis
Crone's disease
IBS
Constipation
Diarrhea
Gas/bloating
Diverticulitis
Chronic Indigestion
Fatigue
GERD
Hernia(s)
Other
_____

_____

Circulatory:
Stroke
Blood clots / DVT
High blood pressure
Low blood pressure
Peripheral artery disease
Raynaud's Syndrome
Varicose veins
Hemophilia
Pacemaker
Phlebitis
Heart Problems:

_____

_____

Skin:
Fungal infections
Athlete's foot
Eczema/Dermatitis
Psoriasis
Cellulitis
Itching
Rash of Unknown Origin
Easily irritated skin
Allergies:

_____

_____

Nervous System:
Dizziness
Multiple sclerosis
Parkinson's
Neuropathy
Spinal cord injury
Seizures/Epilepsy
Other:

_____

_____

Other:
AIDS/HIV
Diabetes
Pregnancy
Cancer
Hepatitis
High Stress/Anxiety
Bipolar
Insomnia
Known Allergies

_____

_____

Other:

_____

_____

I acknowledge, that massage is NOT a substitute for medical examination or diagnosis. I have stated all medical conditions that I am aware of, and I will update the massage practitioner of any changes in my health.

Signature _____ Date: _____