Date: _____

Name: _____ Age: _____ Birth Date: _____

Phone: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation:_____

Referred by: _____

Emergency Contact: _____

Phone: _____ Relation: _____

Please check all that apply both currently and previously:

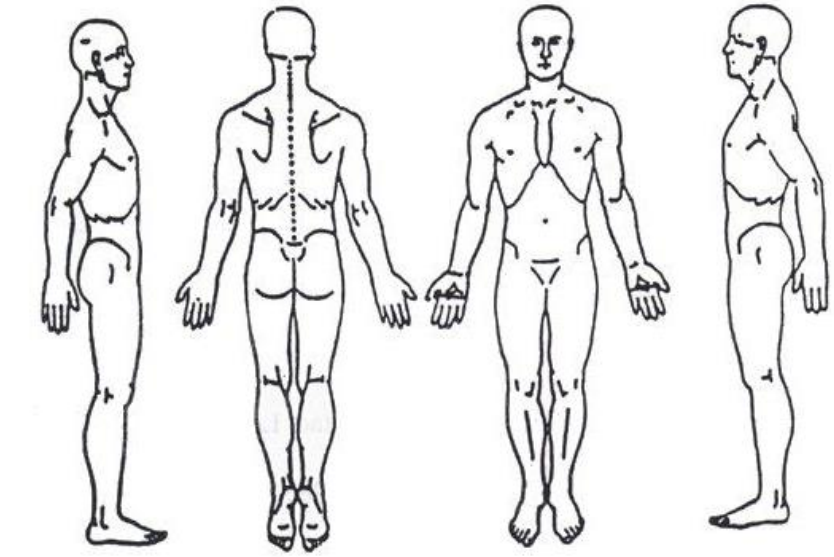
- Allergies To What: _____
- Skin Conditions Location: _____
- Varicose Veins Location: _____
- Blood Clots / Atherosclerosis
- Heart Problems Type: _____
- Diabetes Type: _____ Insulin Dependent? _____
- Hypo / Hyperthyroidism _____
- Asthma Is it well regulated? Y N Are you on an inhaler? Y N
- Problems with alcohol or drugs
- Arthritis or Bursitis Location: _____
- HIV / AIDS / Other Other:_____
- Back Pain / Disc Problems Location: _____
- High / Low Blood Pressure
- Chronic Headaches or Migraines
- Cancer / Cancer Treatment Type: _____ Status: _____
- Bruxism (clenching or grinding of teeth)
- Currently Pregnant or Lactating Weeks: _____
- Other: _____
- Injuries (Broken bones, sprains, strains, whiplash, traumas, etc. And Dates) _____
  _____
  _____
  _____
- Surgeries Type and Dates:
  _____
  _____
  _____

Please list all medications and/or supplements that you are currently taking and why:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(see reverse)

Please indicate any areas of pain, discomfort, or tension you are currently experiencing or have come here to address:



Use the space below to elaborate on the type of pain, discomfort, or tension, and anything else you can tell me about onset, triggers, patterns, relief or etc.

_____
_____
_____
_____
_____

Please specify any areas of the body to be avoided: _____
Reason: _____

Do you exercise? Y N # of Times per Week: 1-2 3-4 5-7
Type of Exercise: _____

Please list any other therapies you are currently involved in, the frequency of the treatments, and the condition being treated: _____
_____
_____
_____

Other information you feel would be important or helpful to share at this time:
_____
_____

Please take a moment and carefully read the following information. Sign where indicated.

Massage / Bodywork is contraindicated for certain medical conditions and symptoms. As such, a referral from a primary care provider may be required prior to beginning a massage session. I affirm that I have stated all my known medical conditions, and answered all questions in my intake paperwork honestly. I agree to keep Summit Therapeutics updated as to any changes in my medical standing, and understand that there shall be no liability on the therapists's part should I forget to do so. I understand that the massage/bodywork I receive is provided for the specific purpose of relaxation and relief from muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted. I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. Checking the box below confirms my agreement to these statements.

Signature: _____ Date: _____