The Healing ZONE **CONFIDENTIAL INTAKE 2024**

PLEASE PRINT (clearly)

Name:_____

Address:_____

City:_____ **State:**_____ **Zip**_____

Cell Phone:_____ **Use TXT? No Yes** **UMASS employee ID:** _____

E-mail:_____ **Date of Birth:**_____

How did you hear about The Healing ZONE? Internet, Facebook, Event, Friend: _____
Have you had Massage Therapy before? Yes ( ) No ( ) When? _____
Please list any **medications** you take regularly:_____
_____
Are you involved in a regular exercise/ how often?_____
What is your activity level? _____
Any medically related **restrictions?** Yes No Position restrictions? Yes No
Please explain_____

DO YOU HAVE ANY OF THE FOLLOWING? IF SO, PLEASE CHECK BOX to the LEFT:

	Allergies (nuts, scents)		**COVID-19** or Long **COVID**		**Lymphedema** Risk or History
	Anxiety		Depression		Neuropathy
	Arthritis		Diabetes (injection site)		**Osteoporosis** fragile bones
	Asthma		Dizziness		Pacemaker / Port
	Blood clots / History of DVT		Epilepsy		Pins or plates
	Blood Pressure: ( )High ( ) Low		Headaches/how often?		**Pregnancy** _____ week Due date
	Bruising tendency		Heart disease		Sensitive Skin
	Cancer-Type: **Active treatment**		Hemophilia		Swelling /Where?
	Cancer-personal history **Type: When:**		Hernia		Varicose veins

Have you been vaccinated? Yes No Have you had Covid-19? Yes No
Any lingering effects:_____

Please read and sign to indicate your content to receive massage at The Healing Zone:

It is my choice to receive massage or bodywork. I realize the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm or pain. I understand that therapists do not diagnose illness or prescribe medical treatment. I am responsible for consulting a PCP for any ailments I may have. I have stated all medical conditions and medications.

Signature:_____ Date:_____