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Health Intake

Name: _____ DOB: _____

Please describe your **primary concern** or issue that you are considering addressing with Thai Massage:

_____
_____
_____

Please describe the **history** of your primary concern or issue:

_____
_____

Please describe any **secondary concerns** or issues:

_____
_____
_____

Do you have, or have you had any of the following (**check all that apply**):

- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ High Cholesterol
- ○ Heart/Circulatory Disease
- ○ Organ Disease
- ○ Chronic Indigestion
- ○ Peptic Ulcer
- ○ Chronic Constipation
- ○ Irritable Bowel
- ○ High Stress
- ○ Nervousness/Anxiety
- ○ Diabetes
- ○ Frequent Headaches
- ○ Fatigue/Weakness
- ○ Hormone Imbalance
- ○ Irregular Menstruation
- ○ Cancer
- ○ Other: _____

Are you now, or could you be **pregnant**? Yes / No

Please describe any past **surgeries or medical procedures** (give dates):

_____
_____

Please list current **medications**, vitamins & supplements (dosage and frequency):

_____
_____
_____

Please describe your **appetite/diet**:

_____
_____
_____

Please describe your **caffeine/nicotine/alcohol/drug** intake:

_____
_____
_____

Please describe what forms of **exercise** you do and how frequently:

_____
_____
_____

Any additional information you feel would be helpful:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____