



## Integrated Health Care New Patient Information

**STOP...** IF YOU ARE CURRENTLY SEEING ANOTHER SPECIALIST AT INTEGRATED HEALTH CARE  
PLEASE SKIP THE TOP FORM.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(first) (middle) (last)

**Nickname:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Gender:** M / F

**Marital Status:** Single Married Divorced Widowed

**Mailing Address:** \_\_\_\_\_  
(street) (city) (zip code)

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Which phone number would you like us to use for reminder phone calls?** ☐ Home ☐ Cell

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Work Status:** ☐ Full time ☐ Part-time ☐ Retired

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Are you allergic to any foods, drugs, medications, or metals?** Y / N

If yes, please describe: \_\_\_\_\_

**When did you last receive health care and for what reason?** \_\_\_\_\_

**Primary reasons for appointment?** \_\_\_\_\_

**\*If you are seeing more than one specialist at Integrated Health Care do you give permission for those specialists to discuss your healthcare and treatments as to better resolve your health concerns?** Y / N Please sign here: \_\_\_\_\_

**How did you hear about Integrated Health Care?** \_\_\_\_\_



Allyson Cook, & Associates, Licensed Massage Therapists

OVER ➡

455 State Rd. Vineyard Haven, MA 02568  
508.696.1863

## **Health History Form**

Please clearly complete both sides of this form. This information is crucial for your individualized massage therapy treatment. All information provided is kept confidential.

Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

Please circle any areas of complaint/pain, tension, and/or where you tend to hold your stress:

|           |            |          |                      |
|-----------|------------|----------|----------------------|
| Head/Face | Low Back   | Neck     | Shoulders/Upper Back |
| Legs/Feet | Arms/Hands | Mid-Back | Other: _____         |

Have you ever had a massage therapy session before? \_\_\_\_\_ How many? \_\_\_\_\_

Please indicate any likes/dislikes of past massages sessions: \_\_\_\_\_

What is the amount of tension in your life? 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10  
(none) (average) (extreme)

What physical activities do you do on a regular basis? \_\_\_\_\_

How Often? \_\_\_\_\_ Do you stretch? \_\_\_\_\_

Have you had any injuries/surgeries in the last 2 years? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Do you take any medication regularly? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Please circle any of the following health issues that you have had in the past year:

|                                      |                 |                             |
|--------------------------------------|-----------------|-----------------------------|
| Asthma/Allergies                     | Heart Disease   | Phlebitis/Thrombosis        |
| High/Low Blood Pressure              | Blood Clots     | Varicose Veins              |
| Respiratory Conditions               | Diabetes        | Gastrointestinal Conditions |
| Congestive Heart Failure             | Cancer          | Hepatitis                   |
| Whiplash/Disc Problems               | Fibromyalgia    | Migraines/Headaches         |
| Skin Conditions                      | Arthritis       | Repetitive Strain Injuries  |
| Carpal Tunnel Syndrome               | Sciatica        | Pregnancy                   |
| Immune System Conditions             | Hospitalization | Surgery                     |
| Liver, Kidney, or Urinary Conditions |                 | Other: _____                |

**Please describe any conditions/issues circled above and specific complications that occurred:**

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**Please read and sign:**

I verify that all of the above information provided is correct and current to the best of my knowledge. I understand that the information provided will be kept confidential and disclosed only with written consent by me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you and please enjoy your session!**

**24 HOUR NOTICE IS REQUIRED PRIOR TO CANCELING AN APPOINTMENT.  
BARRING EMERGENICES, MISSING AN APPOINTMENT WITHOUT PROPER NOTICE WILL RESULT IN A FEE, DUE  
AND PAYABLE IMMEDIATLEY.**

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