ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic
The Springs Integrative Medicine Center and Spa

Health History Intake Form

Name _____ Date of Birth _____ Today's Date _____

What reasons are you seeking treatment at The Springs?_____

_____

For WOMEN, are you pregnant or trying to become pregnant? ☐YES ☐NO If Yes, #_____ weeks gestation

MEDICATIONS – Do you take/use any of the following medications?

Prescription blood thinners (ex. Coumadin, Warfarin, Heparin)?	☐YES ☐NO
Statin drugs for cholesterol?	☐YES ☐NO
Retin-A, Renova, AHAs, Retinol/Vit A derivative products?	☐YES ☐NO
Accutane	☐YES ☐NO

ALLERGIES

Drugs/Medications	☐YES ☐NO	Specify:
Gluten	☐YES ☐NO	Specify:
Iodine/Seafood	☐YES ☐NO	Specify:
Other Foods	☐YES ☐NO	Specify:
Plants/Environmental	☐YES ☐NO	Specify:
Other	☐YES ☐NO	Specify:
Skin sensitivities/reactions to products/ingredients	☐YES ☐NO	Specify:

MAIN MEDICAL HISTORY (Please include dates):

Medical Diagnoses:
Surgeries:
Injuries:

Who is your Primary Care Doctor? _____

Please list names of any Specialists you see: _____

DO YOU HAVE NOW, OR IN THE PAST ANY OF THE FOLLOWING:

Condition/Symptom	**NOW**	**PAST**				
Diabetes	☐	☐		Cancer	☐	☐
Memory Loss	☐	☐		Type: _____		
Light Headed/Dizzy/Vertigo	☐	☐		When: _____		
Fainting/Loss of Balance	☐	☐		Treatment: _____		
Falls	☐	☐				
Blood Clots or Phlebitis	☐	☐		Lymph Nodes Removed?	☐	☐
Heart Disease	☐	☐		How many? _____		
High Blood Pressure	☐	☐		Where? _____		
Low Blood Pressure	☐	☐				
Have you had a stroke?	☐	☐				
Swelling/Edema	☐	☐				

Please list any other medical conditions, symptoms, or situations that practitioner should be aware of prior to your treatment:

_____

_____

The information I have provided is true and complete to the best of my knowledge. I agree to inform my practitioner of any changes in my health prior to treatment.

_____ _____

Patient Signature Date

Consent for Massage/Hydrotherapy/Facial/Nail & Body Treatments

1. I hereby authorize massage therapy, hydrotherapy or body wraps/scrubs, facial, waxing, or nail treatments at The Springs Integrative Medicine Center & Spa at Clifton Springs Hospital & Clinic.
2. The treatment(s) recommended to treat my condition, if applicable (has/have) been explained to me, and I understand the nature of the treatment(s) to be non-diagnostic in nature. These treatments do not take the place of medical care from a physician.
3. The benefits, risks and consequences that are associated with the treatment(s) have been explained to me. In addition, possible alternatives to the treatment(s) and risks of no treatment have been explained to me.
4. I understand the explanation of the risks and consequences I have received is not exhaustive and other, more remote, risks and consequences may arise. I have been advised that these more remote risks and consequences will be explained to me upon request. I acknowledge I have been given the opportunity to ask questions concerning this treatment(s), its risks and consequences, and my questions, if any, have been answered to my satisfaction.
5. I acknowledge I have informed my therapist of any medical conditions I have.
6. I acknowledge I have received no guarantee concerning the treatment(s) to which I am consenting.
7. I acknowledge I have read or have had this document explained to me in its entirety and I fully understand it.

Signature of Patient _____ Date _____ Time _____ AM/PM

Provider's Signature _____ Date _____ Time _____ AM/PM

If client is unable to sign or is a minor, complete the following:

Check one:

☐ Patient is a minor _____ years of age.

☐ Patient is unable to understand benefits and/or risks of consenting or not consenting to treatment(s)

Parent or Guardian Name _____ Relationship _____

Signature of Authorized Individual _____ Date & Time _____