Intuitive Touch Confidential Intake Form **Date:________________________**

Name ______________________ Date of Birth _________ Phone ___________________Email __________________

City_______________ State_____ Emergency Contact (name, number, relation) ____________________________

Occupation/employer __________________Physician:_____________________ Phone:______________Permission to consult? N/YPreferred appointment days and times:________________________How did you learn about this office? __________

Goals for this treatment:____________________________________**Present Symptoms** ___________________

Areas you **don't** want worked? Arms Legs Hands Feet Face Head Stomach Buttocks Other __________________

List all **medications**/herbs/vitamins and dosage: ____

____

Are you currently being **treated**, medically? (Please describe.) _____________________________________

____

What **aggravates** the condition most?___________________________ What activities are **limited**?_______________

List **physical activities** you participate in regularly____

List previous major injuries/surgeries and approximate dates: ____

Medical History and Information (Check all that apply. Indicate **C for Current; P for Past**)

___ headaches, migraines ___ numbness/tingling ___varicose veins ___whiplash

___ sleep difficulties ___pregnancy ___blood clots ___HIV

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___ sinus problems	___painful menstruation	___high/low blood pressure	___bursitis
___ jaw pain/teeth grinding	___digestive problems	___diabetes	___phlebitis
___ fatigue	___scoliosis	___cancer/tumors	___ hemophilia
___ depression, anxiety	___arthritis	___osteoperosis	___TOS
___ sprains/strains	___tendonitis	___skin problems/rashes/allergies	___torticolis
___ muscle or joint pain	___ heart disease, stroke	___respiratory problems	___TMJ
___ parkinson's disease	___trigeminal neuralgia	___multiple sclerosis	___ hepatitis,TB
___ bell's or cerebral palsy	___herpes or shingles	___muscular dystrophy	___TBI, confusion
___broken bones	___ neuritis	___infectious disease, contagion	___cold
___ spinal chord injury	___ epilepsy/seizures	___kidney disease	___flu

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage practitioners are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing should be construed as such. Because massage should not be performed under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to provide printed updates to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination and full payment of the session. Understanding there are risks, including COVID-19, I give my consent to receive care. I am also aware that communications through email, text, etc. are not encrypted or secure, and I will provide information that I want to be private by phone or in person. I agree to provide a 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.

Parent Name & Signature (in case of a minor)____ Date ______________________

Signature ____ **Date** ______________________________

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