

Intuitive Touch Confidential Intake Form

Date: _____

Name _____ Date of Birth _____ Phone _____ Email _____

City _____ State _____ Emergency Contact (name, number, relation) _____

Occupation/employer _____

Primary Care Physician: _____ Phone: _____ Permission to consult Physician? No/Yes

Preferred 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 any or all that apply to your past or present health) (Back of form→)

___ headaches ___ numbness/tingling ___ varicose veins ___ whiplash

Intuitive Touch Confidential Intake Form

Date: _____

Name _____ Date of Birth _____ Phone _____ Email _____

City _____ State _____ Emergency Contact (name, number, relation) _____

Occupation/employer _____

Primary Care Physician: _____ Phone: _____ Permission to consult Physician? No/Yes

Preferred 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 any or all that apply to your past or present health) (Back of form→)

___ headaches ___ numbness/tingling ___ varicose veins ___ whiplash

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> pregnancy | <input type="checkbox"/> blood clots | <input type="checkbox"/> HIV |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> painful menstruation | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> digestive problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer/tumors | <input type="checkbox"/> hemophilia |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease | <input type="checkbox"/> TOS |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems/rashes/allergies | <input type="checkbox"/> torticollis |
| <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> heart disease | <input type="checkbox"/> respiratory problems | <input type="checkbox"/> TMJ |

Nervous System and other Disorders

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> trigeminal neuralgia | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> bell's palsy | <input type="checkbox"/> herpes or shingles | <input type="checkbox"/> muscular dystrophy | <input type="checkbox"/> TB |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> neuritis | <input type="checkbox"/> infectious disease | <input type="checkbox"/> cold |
| <input type="checkbox"/> spinal chord injury | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> kidney disease | <input type="checkbox"/> flu |

I have completed this form to the best of my knowledge and consent to receive massage therapy. I affirm that I have stated all known medical conditions because massage should not be performed under certain circumstances. I agree to keep my practitioner informed if changes occur in my medical profile. I understand that massage therapy is a therapeutic health aid and is non-sexual. If at any time I feel discomfort, I agree to inform the therapist, immediately. The massage therapist will not know that unless I inform her. I understand that massage/bodywork is provided basically for the purpose of relaxation and relief of muscular tension. I understand that massage therapists do not diagnose illness, disease, or any mental or physical disorder. I acknowledge that massage is not a substitute for medical exams or diagnosis, and that it is recommended that I see a primary health care provider for that service. I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee.

Signature _____ Date _____

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> pregnancy | <input type="checkbox"/> blood clots | <input type="checkbox"/> HIV |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> painful menstruation | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> digestive problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer/tumors | <input type="checkbox"/> hemophilia |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease | <input type="checkbox"/> TOS |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems/rashes/allergies | <input type="checkbox"/> torticollis |
| <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> heart disease | <input type="checkbox"/> respiratory problems | <input type="checkbox"/> TMJ |

Nervous System and other Disorders

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> trigeminal neuralgia | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> bell's palsy | <input type="checkbox"/> herpes or shingles | <input type="checkbox"/> muscular dystrophy | <input type="checkbox"/> TB |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> neuritis | <input type="checkbox"/> infectious disease | <input type="checkbox"/> cold |
| <input type="checkbox"/> spinal chord injury | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> kidney disease | <input type="checkbox"/> flu |

I have completed this form to the best of my knowledge and consent to receive massage therapy. I affirm that I have stated all known medical conditions because massage should not be performed under certain circumstances. I agree to keep my practitioner informed if changes occur in my medical profile. I understand that massage therapy is a therapeutic health aid and is non-sexual. If at any time I feel discomfort, I agree to inform the therapist, immediately. The massage therapist will not know that unless I inform her. I understand that massage/bodywork is provided basically for the purpose of relaxation and relief of muscular tension. I understand that massage therapists do not diagnose illness, disease, or any mental or physical disorder. I acknowledge that massage is not a substitute for medical exams or diagnosis, and that it is recommended that I see a primary health care provider for that service. I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee.

Signature _____ Date _____