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 all that apply. Indicate **C for Current; P for Past**)

___ headaches, migraines	___ numbness/tingling	___varicose veins	___whiplash
___ sleep difficulties	___pregnancy	___blood clots	___HIV
___ 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

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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** _____