

## 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

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<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"/> torticulis
<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 \_\_\_\_\_

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