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
___ sleep difficulties
___ sinus problems
___ jaw pain/teeth grinding
___ fatigue
___ depression
___ sprains/strains
___ muscle or joint pain
___ numbness/tingling
___pregnancy
___painful menstruation
___digestive problems
___scoliosis
___arthritis
___tendonitis
___ heart disease
___varicose veins
___blood clots
___high/low blood pressure
___diabetes
___cancer/tumors
___infectious disease
___skin problems/rashes/allergies
___respiratory problems
___whiplash
___HIV
___bursitis
___phlebitis
___ hemophilia
___TOS
___torticolis
___TMJ

Nervous System and other Disorders

___ parkinson's disease
___ bell's palsy
___cerebral palsy
___ spinal chord injury
___trigeminal neuralgia
___herpes or shingles
___ neuritis
___ epilepsy/seizures
___multiple sclerosis
___muscular dystrophy
___infectious disease
___kidney disease
___ hepatitis
___TB
___cold
___flu

I have completed this form to the best of my knowledge and consent to receive massage therapy with understanding of the risks associated with receiving care, not limited to the COVID-19 risks. 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 ___________________________________