Confidential Intake Form

Name: _____ DOB: ___/___/___

Address: _____ City _____ State _____ Zip _____

Best contact number: (_____) _____ - _____ Email: _____ (optional)

Emergency Contact: _____ Phone: _____ Relationship: _____

Occupation: _____ Hobbies/extra curricular activities: _____

Have you had a massage /body work done in the past? Y/N Last massage? _____ How did you hear about us? _____

Describe any past surgeries, injuries, or hospitalizations: _____

_____

Are you currently experiencing any pain or restricted movements (i.e. I can't turn my head to the left):

Please describe: _____

Please list any current medications: _____

Are you pregnant? Y/N Due Date: _____

Please circle any that apply:

Numbness/Tingling	Varicose veins	Nausea/Diarrhea	Diabetes
Epilepsy/Seizures	Blood Poisoning	Sinus Problems	Headache
Infectious Disease	Skin issues	Depression	Sleep difficulty
Jaw Pain/Teeth grinding	Tendonitis	Arthritis	Osteoporoses
High/Low Blood Pressure	Blood Clots	HIV/AIDS	Cancer/Tumors
Shortness of breath	Asthma	Fatigue	Kidney disease

Other _____

_____

_____

I understand that my therapist cannot treat, diagnose, and/or prescribe. If I am experiencing and major health problems I may need to see my doctor for diagnoses and/ or treatment. I have the right of refusal any time in my appointment. I understand that I may be denied services if I have behaved inappropriately during the session or have consumed drugs or any intoxicating substances prior to my appointment. I understand I need to give my therapist at least 24 hours of notice for any cancelation or I may be charged in full for the missed service. I agree to comply with the stated policy.

X _____ X ___/___/___ X _____ X ___/___/___

(Client Signature) (Date) (Signature of Parent /Guardian) (Date)