Positive Change

INTAKE FORM

Name:_____Date:_____

Address:_____

City:_____State:_____ Zip:_____

Phone:_____Email:_____

Emergency contact:_____Phone:_____

PLEASE ✓ AND EXPLAIN ANY OF THE FOLLOWING CONDITIONS.

Skin	Reproductive	Joints / Bones
▢ Infectious Disorders	▢ *Pregnant, nursing or trying to conceive	▢ Stiffness
▢ Ringworm	▢ *Due date_____	▢ Pain
▢ Psoriasis	▢ Currently menstruating	▢ Inflammation
▢ Athletes Foot	▢ Cysts, tumors	▢ Dislocation
▢ Fungus	▢ Inflammation	▢ Degeneration Joint disease,
▢ Infection	▢ Cramping / Spasms	▢ Bone Spurs
▢ Cellulitis	▢ Recent procedures	▢ Osteopenia / Osteoporosis
▢ Rashes		▢ Tendonitis / Bursitis
▢ Topical/Nut Allergies		▢ Arthritis / Gout
▢ New Tattoo		

Surgeries Augmentation / Implants When?	Musculoskeletal	Bones / Foot
▢ Lips	▢ Muscle pain or weakness	▢ Broken Bone - when?
▢ Cheeks	▢ Cramping or Spasms	_____
▢ Breast (sub pectoral or sub glandular?)	▢ Neck Injury or Whiplash	▢ Plantar Fasciitis, bunion, neuroma, bone spurs
▢ Pectorals ▢ Deltoid	▢ Carpel Tunnel Syndrome	▢ plantar warts
▢ Glutes ▢ Calves	▢ Thoracic Outlet Syndrome	▢ athlete's feet
▢ other	▢ Jaw Pain / diagnosed TMJD	Please explain anything ✓ or not listed (*use 3rd page of the form*).

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Circulatory / Cardiovascular
- ▢ Blood Clots or Blood
- ▢ Thinning Meds
- ▢ Aneurism
- ▢ Phlebitis
- ▢ Varicose Veins
- ▢ Heart Conditions
- ▢ Stents/Shunts

Nervous System Neurological Condition
- ▢ Sciatica
- ▢ Numbness
- ▢ Decreased sensation, loss of motor control, shooting pain, tingling
- ▢ Stroke-when?

Autoimmune
- ▢ Lupus -flared?
- ▢ Multiple Sclerosis
- ▢ Fibromyalgia

Other
- ▢ Diabetes
- ▢ Cancer
- ▢ Lymphatic issues / Edema

Circulatory / Cardiovascular
- ▢ Pacemaker
- ▢ Low or High Blood Pressure
- ▢ High Cholesterol
- ▢ Hemophilia
- ▢ Poor Circulation / Reynauds

- ▢ Epilepsy
- ▢ Seizures
- ▢ Fainting

Stress Level
- ▢ High
- ▢ Medium
- ▢ Low

Eye / Optical issues
- ▢ Eye Strain
- ▢ Optical Nerve Issues
- ▢ Eye Surgery
- ▢ Lasik
- ▢ Currently Wearing Contacts

Injections / Shots
- ▢ Cortisone
- ▢ Epidural Steroid
- ▢ Nerve Blocks
- ▢ Trigger Point Injection
- ▢ Flu shot
- ▢ Vaccines
- ▢ Hormones

Hernia
- ▢ Abdominal
- ▢ Hiatal
- ▢ Inguinal

Metal
- ▢ Laminectomy
- ▢ Rods
- ▢ Fusions
- ▢ Screws / bolts / pins / plates
- ▢ Cages
- ▢ Joint replacements

Other
- ▢ Claustrophobia
- ▢ HIV
- ▢ PTSD
- ▢ Dizziness or Vertigo

- ▢ Headaches or Migraines (where and when?)

Spine issue
- ▢ Coccyx injury
- ▢ Scoliosis
- ▢ Spondylolethesis
- ▢ Spondylitis
- ▢ Stenosis
- ▢ Degenerative Disc Disease

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Please list all supplements & medications. Please Clarify anything from above ↓

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that complete draping with a sheet will be used throughout my session except in the case of a clothed massage._____(initial)

It is my responsibility to voice any concerns and offer instant feedback to my therapist if pressure, pain, temperature sensitivities or any other comfort issues arise during my session._____(initial)

THERAPEUTIC AGREEMENT
All health concerns listed above are true and thorough; I have not withheld information regarding my health history.

Client Signature: _____

Date: _____