Amy Moses LMT
Integrative Massage & Bodywork
Craniosacral Therapy

Confidential Client Intake Form

Name:_____ Date of Initial Visit_____

Address_____State_____Zip_____

Home Phone_____ Cell Phone_____Work Phone_____

Email_____

In case of emergency, contact:_____ Phone number:_____

Date of Birth_____ Age_____Occupation_____

Have you had massage/bodywork before?_____ What type(s)?_____

What kind of pressure do you like? Light_____ Medium_____ Deep_____

How did you hear about me?_____

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

When did you first notice it?_____What brought it on?_____

What activities provide relief?_____What makes it worse?_____

Does this condition interfere with work_____ sleep_____ recreation_____

Describe your exercise routine (type, frequency)_____

MEDICAL HISTORY

Are you currently under the care of another health care provider(s)? YES NO

Reason(s)_____

Any Surgeries or Acute Injury? Please Describe_____

Any type of Breast Surgery? YES NO Prostate Surgery? YES NO

Chemotherapy? YES NO Radiation? YES NO Any Lymph Nodes Removed? YES NO

Current Medications:_____

_____

Allergies?_____

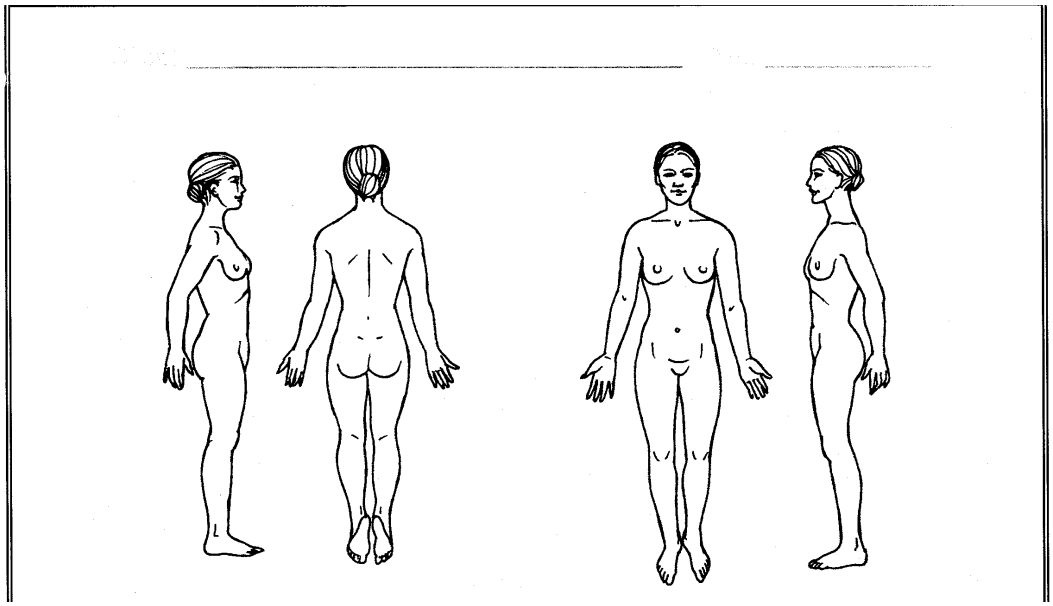
Supplements/Remedies_____

Circle any of the following you are *Currently* experiencing
Underline and of the following you have experienced in the *Past*

Headaches (migraine, tension, cluster)		Stress	Pins and needles in arms, legs, hands or feet	
Asthma	Cold Hands or Feet	Swollen ankles	Sinus Conditions	Herniated / Bulging discs
Skin Disorders: ex: *Acne, Fungus, Psoriasis*		Sciatica	Spinal Problems	Painful Joints/Swollen Joints
Contagious Diseases		Arthritis	Fatigue	Trouble Sleeping
Varicose Veins / Blood Clots		Seizures	Osteoporosis	High or Low Blood Pressure

If applicable, are you, or could you be, pregnant?_____

Mark Any areas of current persistent pain or tension on the figures below:



Please read and sign

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

I agree to give at least 24 hours notice of cancellation of appointment. If the session is cancelled within the 24 hours, full payment is expected. Cases of emergency and bad weather are considered exceptions to this cancellation policy. Thank you.

I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice). As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice). I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature_____Date_____