

Massage & Cranio-Sacral Therapy Intake Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Other names/Maiden Name: _____ Birthdate: ____/____/____ Sex: M / F

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Full Time: Y / N

Emergency Contact: _____ Relationship to Patient: _____

Contact's Phone Number: _____ Contact's Email: _____

Please List any **Life Threatening Allergies:** _____

Referred to Dr. Emily Telfair by: _____

Current Health Care Team:

Primary Care Physician: _____ Office Number: _____

Specialist Physician: _____ Specialty: _____ Office Number: _____

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):

Practitioner Name: _____ Office Number: _____

Practitioner Name: _____ Office Number: _____

Primary Health Concerns: *Please list you primary health concerns in order of importance.*

<u>Concern</u> <i>Ex: Headache</i>	<u>Onset</u> <i>June 1978</i>	<u>Frequency</u> <i>4 times/week</i>	<u>Severity</u> <i>mild/mod/severe</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Have you ever received Massage therapy? Y / N

If yes, when was your last treatment? _____

Have you ever received CranioSacral therapy? Y / N

If yes, when was your last treatment? _____

List all current medications, supplements, herbal remedies, etc: _____

(OVER PLEASE)

PERSONAL MEDICAL HISTORY

List and include dates if possible:

- Surgeries:

- Accidents/Injuries:

- Major Illnesses/Hospitalizations:

Please mark any of the following conditions you have now or have *significant history of in the past.*

General

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Headaches:
<input type="checkbox"/>	<input type="checkbox"/>	Pain:
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance:
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue:
<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis:
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Muscles and Joints

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Disease:
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis:
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones:
<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis/Bursitis:
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis:
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis:
<input type="checkbox"/>	<input type="checkbox"/>	Disc Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Lupus:
<input type="checkbox"/>	<input type="checkbox"/>	Sprain/Strain:
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain/TMJ:
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Shoulder/Arm Pain:
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Low back Pain:
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Ankle Pain:

Nervous System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Head injuries/Concussions:
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Ringing in ears:
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling:
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica/Shooting pains:
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve:

<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy:
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Endocrine System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition:
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Respiratory/Cardiovascular

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition:
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots:
<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure:
<input type="checkbox"/>	<input type="checkbox"/>	Stroke:
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat:
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation:
<input type="checkbox"/>	<input type="checkbox"/>	Edema/Swollen Ankles:
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Short of Breath:
<input type="checkbox"/>	<input type="checkbox"/>	Asthma:

Digestive/Elimination System

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea:
<input type="checkbox"/>	<input type="checkbox"/>	Gas/Bloating:
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome:
<input type="checkbox"/>	<input type="checkbox"/>	Gastric Ulcers:
<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Kidney Dysfunction:
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Reproductive

Current	Past	Comments
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy: --
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems:

ρ ρ Prostate problems:

ρ ρ Tobacco Use:

ρ ρ Other:

ρ ρ Drugs:

Other

Current Past Comments

ρ ρ Cancer:

ρ ρ Alcohol:

ρ ρ Other:

ρ ρ Anxiety/Stress:

I understand that Massage & CranioSacral therapy are not substitutes for standard medical care and I have indicated all of my known medical conditions above. I will alert the practitioner to any changes in my health status. It is my choice to receive Massage or CranioSacral therapy with an understanding of the risks and benefits and I give my consent for treatment. I understand that there is no stated guarantee for effectiveness of treatment. I understand that my records will be kept in strict confidence.

PAYMENT POLICIES

Full payment is due at the time of service. Dr. Telfair requests 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the client will be charged half of the original visit fee except in the case of family or medical emergency. No-show appointments will be charged the full visit fee. This charge will be applied to the following visit or billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

Signature: _____

Date: _____