INTAKE FORM

Kathryn Stover
LMT, CST, MMT
727-687-8598

Date_____

Name:_____
Last First Middle

Address: _____
Street number Street Name City State Zip

Phone: Home: _____ Work: _____

Phone: Cell: _____E-mail address: _____

Birth date: _____ Gender: M F Height: _____ Weight: _____

Occupation: _____ Referred by: _____

Physical Activities/Hobbies:_____

Emergency contact/relationship:_____

Phone #: Cell_____Work/Home_____

During the **past 2 years**, have you had any of the following? Please mark the box of those which apply to you..

❒ Cancer ❒ Heart Disease/ByPass Surgery ❒ High Blood Pressure ❒ Tuberculosis ❒ Surgery

❒ Hepatitis ❒ AutoImmune Deficiency ❒ Diabetes ❒ Broken or brittle bones

Do you **currently** have any of the following? Please mark the box of those which apply to you.

❒ Allergies ❒ Skin Lesions/Sensitivities ❒ Joint Problems ❒ Headaches ❒ Seizures (ever)

❒ Dizziness ❒ Bruise easily ❒ Muscle Problems ❒ Back Problems ❒ Pacemaker

❒ Neck Problems ❒ Currently pregnant ❒ Joint Replacement surgery has been performed

❒ Fibromyalgia ❒ Stiffness in moving ❒ Feeling of tightness or or tenderness in muscles

Are you **currently** receiving or taking any of the following?

❒Radiation Therapy ❒Chemotherapy ❒Anti-inflammatories ❒Blood thinners

❒Insulin ❒Anti-depressants ❒Blood pressure medication ❒Pain Medications

Are you taking medication(s) today? No ____ Yes:_____

Name of Current Physician _____Last Doctor's visit: _____

Please list any other medical history/surgeries/accidents/injuries:_____

_____

Have you received a professional massage before? _____ If yes, what was the primary reason?
❒Relaxation ❒Treatment of injury ❒Muscle or joint pain ❒CranioSacral ❒Reiki/Chakra/Other Energy Work
What did you like most? _____ What did you like least? _____

For today do you prefer to receive primarily? ❒Relaxation ❒Treatment of injury ❒Muscle or joint pain
❒CranioSacral ❒Reiki ❒Chakra Balancing

Are you in any discomfort or pain today? ❒ No ❒ Yes Please check those areas below:

❒Feet/Ankles ❒Calves ❒Knees ❒Thighs ❒Legs ❒Hips ❒Back

❒Stomach ❒Arms ❒Shoulders ❒Hands ❒Neck ❒Face/Jaw/Head:

Please continue on reverse side