

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_ Mobile/Home

Address: \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Pronouns: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

.....

**Reason for your appointment today:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your short and/or long term goals that you would like me to help you with?**

Exercise/movement goals, general health goals, pain relief, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check the list of things you are currently doing or have done for yourself to achieve these goals?**

Exercise/Movement: \_\_\_\_\_ How often? \_\_\_\_\_ x week

Massage/PT/OT: \_\_\_\_\_ How often? \_\_\_\_\_ x week

Outdoor Activities: \_\_\_\_\_ How often? \_\_\_\_\_ x week

Other: \_\_\_\_\_ How often? \_\_\_\_\_ x week

**Do you have hobbies, or how do you like to spend your free time?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please try to remember if you are or were ever able to do any of these things:**

1. Can you now or could in the past place your hands flat on the floor without bending your knees? Yes  No
2. Can you now or could you ever bend your thumb to touch your forearm? Yes  No
3. As a child you amuse your friends by contorting into strange shapes OR could you do splits? Yes  No
4. As a child or teenager did your shoulder ever dislocate on more than one occasion? Yes  No
5. Do you consider yourself double jointed? Yes  No

(Adapted from Hakim & Grahame's Five part Questionnaire for identifying hypermobility) Answers in the affirmative to 2 or more questions suggest hyper mobility with sensitivity 80-85% and specificity 80-90%.

**Medical History:**

- Medical implants (shunts, ports, pacemakers, stents, etc)

**Have you recently taken any of these:**

- Corticosteroids
- Blood thinners
- Cholesterol medication
- Antibiotics
- Blood pressure medication

**Do you have (or have had in the past)**

- Diabetes
- Osteoporosis
- Osteopenia
- High blood pressure
- Heart disease you are aware of
- Allergies (life threatening)
- Allergies - seasonal/environmental
- Breathing problems
- Autoimmune disorder
- Neurologic disorder
- Vascular disorder
- Skin disorder
- Fibromyalgia
- Concussion

**Skin conditions (now or in the past):**

- Herpes zoster
- Hepatitis (  A     B     C )
- Skin infection (current)
- Psoriasis or eczema
- Bruise easily
- Swelling \_\_\_\_\_
- Lymphedema
- Significant scars \_\_\_\_\_

**Abdomen and Pelvis:**

- Poor digestion
- Constipation
- IBS (Irritable bowel syndrome)
- Chron’s disease
- Appendix removed

**Joint and Muscle Issues:**

- Headaches
- TMJ - Jaw pain      R    L    both
- Neck \_\_\_\_\_
- Arms \_\_\_\_\_
- Back \_\_\_\_\_
- Spine / disc \_\_\_\_\_
- Hip \_\_\_\_\_
- Legs \_\_\_\_\_
- Knee \_\_\_\_\_
- Ankle \_\_\_\_\_
- Foot \_\_\_\_\_
- Muscle cramps
- Shortness of muscles (stiffness)
- Restless leg syndrome
- Sciatica
- \_\_\_\_\_

**Women’s health - Pregnancy & Birth:**

- Currently pregnant
- Natural childbirth (No. \_\_\_\_\_)
- C-Section births (No. \_\_\_\_\_)
- Delivery complications
- Painful periods
- Endometriosis
- Wearing an IUD
- Menopausal (  Peri     Post )
- Painful intercourse
- Hysterectomy
- Prolapse \_\_\_\_\_

- Gallbladder removed
- Stones  gallbladder     kidney
- Gastro esophageal reflux disease
- Diastasis recti

**Other:**

- Arthritis \_\_\_\_\_
- Numbness or tingling anywhere
- Sinus issues
- History of bronchitis / pneumonia
- Ear infections
- Significant respiratory events/history: \_\_\_\_\_
- Significant immunity events/history: \_\_\_\_\_
- Significant cardiac events/history: \_\_\_\_\_
- Significant neurological events/history: \_\_\_\_\_
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Cancer:**

- Cancer \_\_\_\_\_
- Surgery
- Chemotherapy
- Radiation
- Lymph nodes removed
- \_\_\_\_\_

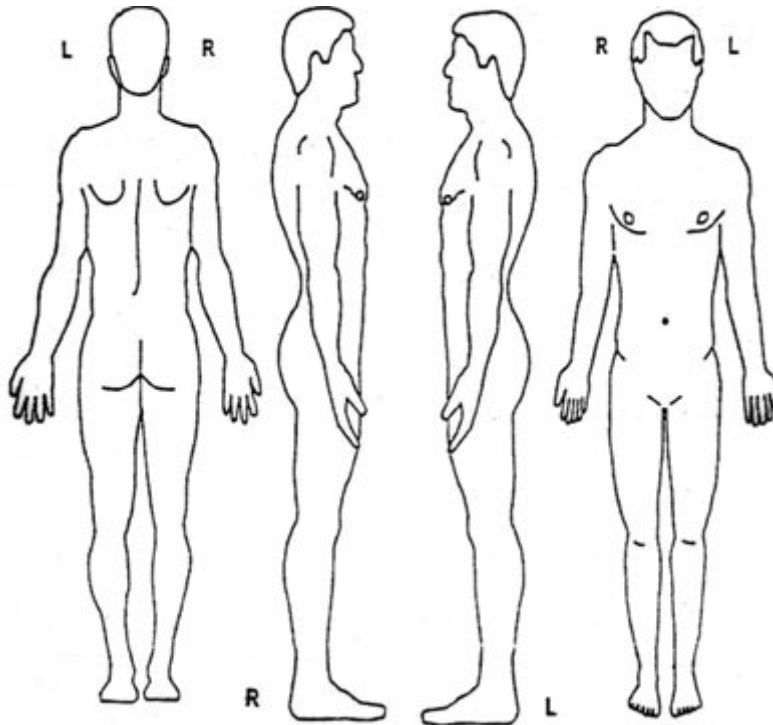
- Pain in pelvic area
- Hemorrhoids
- Hernia \_\_\_\_\_
- Abdominal and/or pelvic surgery

**Special senses. Please circle the frequency of sensory perceptions that happen to you:**

<input type="checkbox"/> Poor balance and falling	yes	sometimes	very rarely	never
<input type="checkbox"/> Afraid of heights	yes	sometimes	very rarely	never
<input type="checkbox"/> Bumping into furniture	yes	sometimes	very rarely	never
<input type="checkbox"/> Uneasy climbing stairs	yes	sometimes	very rarely	never
<input type="checkbox"/> I am very attuned and aware of my body	yes	sometimes	very rarely	never
<input type="checkbox"/> It's hard to relax my body	yes	sometimes	very rarely	never
<input type="checkbox"/> Fabrics bother me	yes	sometimes	very rarely	never
<input type="checkbox"/> Sensitivity to some types of touch	yes	sometimes	very rarely	never
<input type="checkbox"/> Sounds and noise bother me	yes	sometimes	very rarely	never
<input type="checkbox"/> Perfumes/strong smells bother me	yes	sometimes	very rarely	never
<input type="checkbox"/> I always wear sunglasses outdoors	yes	sometimes	very rarely	never
<input type="checkbox"/> I am a clumsy person	yes	sometimes	very rarely	never
<input type="checkbox"/> I avoid crowds	yes	sometimes	very rarely	never
<input type="checkbox"/> I like walking barefoot	yes	sometimes	very rarely	never
<input type="checkbox"/> I struggle with my vision	yes	sometimes	very rarely	never
<input type="checkbox"/> I struggle with my hearing	yes	sometimes	very rarely	never
<input type="checkbox"/> I have double vision	yes	sometimes	very rarely	never
<input type="checkbox"/> I struggle with my sense of smell	yes	sometimes	very rarely	never

**Body Map**

Please mark areas of concern, pain, numbness, tingling, spasms, etc. in your body.



On scale 0-10 where is your level of discomfort today? (0 no pain, 10 = excruciating pain)

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

When did this pain/issue start? \_\_\_\_\_

Anything else you want me to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Subjective Self Evaluation:**

This short questionnaire provides important information about current quality of life as perceived by yourself.  
(10 = Highest most Positive, 0 = Lowest most Negative)

General well being and outlook on life (10 = life is great!) \_\_\_\_\_

Ability to deal with stress (10 = handle stress very well) \_\_\_\_\_

Sleep (10 = sleeping deeply and plenty) \_\_\_\_\_

Social connections (10 = I am surrounded with wonderful humans) \_\_\_\_\_

*Please complete this list for a more comprehensive understanding of your history. Type of event and year in which it occurred:*

**Surgeries:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Concussions:**

\_\_\_\_\_

\_\_\_\_\_

**Broken bones/Fractures:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sprains, strains, and ligament injuries:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other traumas, Injuries, and accidents:**

\_\_\_\_\_

\_\_\_\_\_

## Consent for Therapy

*Please take a moment to read the following, then sign and date where indicated. If you have a specific medical condition or symptoms, a referral from your primary care doctor may be required prior to your therapy.*

I hereby apply and consent to massage therapy from Tjasa Cerovsek Landes (TCL), a Certified Myofascial Therapist, Certified Yamuna body rolling®, Holistic Manual Lymph Drainage Therapist, and a Licensed Massage Therapist in the State of Florida.

I understand that any relief of physical or emotional symptoms is coincidental with alignment and organization of the total human structure, and that alleviation of symptoms is not the primary goal of this therapy approach, rather it is a holistic approach to wellness and health. I understand that results vary from individual to individual and that no specific results can be guaranteed.

I understand that TCL does not treat, diagnose or prescribe for any illness, disease, or any other physical or mental condition. Nothing said or done by the therapist should be construed as such. I understand that the services offered are not a substitute for medical care, and that information provided to me is educational in intent, and **not** diagnostically prescriptive in nature.

I understand that it is necessary for TCL to touch my body in order to provide therapeutic bodywork and massage. I give permission and consent to do all things necessary in helping me establish balance, alignment and relief from my complaints described in this intake form. I know that I am able to and will inform TCL immediately if I experience any pain or discomfort during my session, so that pressure and technique may be adjusted to my level of comfort. I understand that services I receive are strictly therapeutic and non-sexual in intent.

I understand that the information I provide on this form will be confidential, and will be used for no other purpose than treatment protocol and TCL's clinical studies. (A copy of privacy policy is available upon request.) I understand that with my permission and verbal consent my treatment records may be used by the practitioner to consult with other medical providers and specialists in the course of my treatment.

Because massage therapy/bodywork is contraindicated under certain health conditions, I affirm that I have disclosed all known health conditions and answered all questions honestly. I agree to keep the therapist informed as to any changes in my health and my health care, and agree that there shall be no liability on the therapist's part should I not do so.

By signing this form, my consent applies to this session and all subsequent sessions by TCL. I understand that I am financially responsible for my appointments and that payment is due at the time of service. In order to avoid cancellation charges, I agree to give 24 hours notice of cancellation.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

(Parent or legal guardian's signature, if client is a minor)

Parent's Name: \_\_\_\_\_

(Parent or legal guardian's name, if client is a minor)