Name: ______________________________ **Today's Date:** ______________

E-mail: ______________________________ **Phone:** ______________ Cell / Home

Address: ______________________________ **City** ______________ **ZIP** ______________

Sex: F M ______________

Date of birth: ______________ **Pronouns:** ________/________

Occupation: ______________ **Referred by:** ______________

Emergency Contact: ______________ **Relationship:** ______________

Phone number: ______________ **ID verified:** ❑ Driver's License ❑ ______________

Reason for your appointment today:

____

____

____

Check the list of things you are interested in me including in your ongoing wellness care:

- ❑ **Myo-fascial massage** (deeper pressure bodywork)
- ❑ **Massage** as previously applied
- ❑ **Visceral manipulation** (digestive system support)
- ❑ **Lymphatic drainage** (immune system support, edema)
- ❑ **Craniosacral therapy** (head & cranium therapy)
- ❑ **Supportive gentle massage** (I don't like deep pressure)
- ❑ **Movement** (self help education for posture & mobility)
- ❑ **Primitive Reflexes** (simple movement for brain health)
- ❑ **Applied neurological assessments and exercise** (for pain reduction and optimal function)
- ❑ **Cognitive exercises** (improving cognition, preventing neurological degeneration)

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/hobbies: ______________________________ How often? ________ x week

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 you ever 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:

This information is gathered to evaluate potential contraindications, precautions for therapy.

- ❑ Pacemaker
- ❑ Herpes ______________________
- ❑ Hepatitis (❑ A ❑ B ❑ C)
- ❑ Skin infection (current)
- ❑ Psoriasis or eczema
- ❑ Bruise easily
- ❑ Swelling ______________________
- ❑ Lymphedema
- ❑ Significant scars _______________

Abdomen and Pelvis:

- ❑ Digestion/GI pain/problems
- ❑ Constipation
- ❑ IBS (Irritable bowel syndrome)
- ❑ Appendix removed
- ❑ Gallbladder removed
- ❑ Stones ❑ gallbladder ❑ kidney
- ❑ Acid reflux
- ❑ Pain in pelvic area
- ❑ Diastasis Recti
- ❑ Hernia ______________________

Joint and Muscle Problems:

- ❑ Headaches
- ❑ TMJ - Jaw pain
- ❑ Neck ________________________
- ❑ Arms ________________________
- ❑ Back ________________________
- ❑ Herniated disc ________________
- ❑ Hip _________________________
- ❑ Legs ________________________
- ❑ Knee ________________________
- ❑ Foot ________________________
- ❑ Muscle cramps
- ❑ Hypermobility
- ❑ Stiffness
- ❑ _____________________________

Women - Pregnancy & Birth:

- ❑ Currently pregnant
- ❑ Natural childbirth (No.________)
- ❑ C-Section births (No. ________)
- ❑ Delivery complications
- ❑ Painful periods
- ❑ Endometriosis
- ❑ Wearing an IUD
- ❑ Menopausal (❑ Pre ❑ Post)
- ❑ Prolapse _____________________

Other:

- ❑ Arthritis ______________________
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart problem ________________
- ❑ Numbness or tingling anywhere
- ❑ Breathing problems ____________
- ❑ Allergies ______________________
- ❑ Sinus chronic problems
- ❑ History of pneumonia/bronchitis
- ❑ Multiple Sclerosis
- ❑ Fibromyalgia
- ❑ Autoimmune disorder
- ❑ Stroke - year: _________________
- ❑ ______________________________

Accidents/Injuries:

- ❑ Injuries _______________________
- ❑ Car accidents __________________
- ❑ Concussions ___________________
- ❑ Whiplash

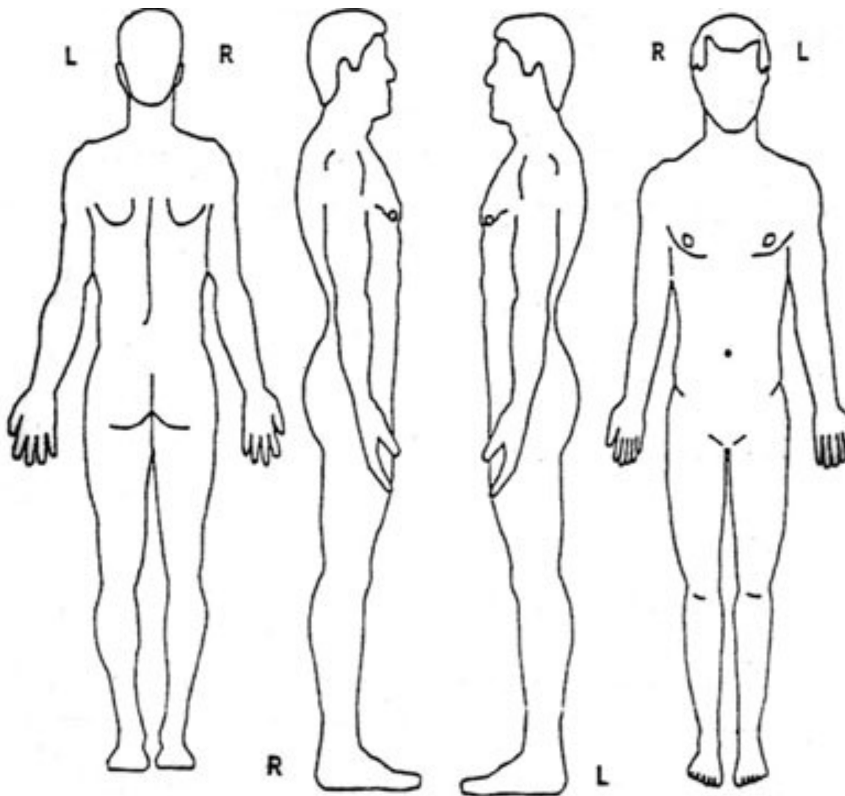
Cancer:

- ❑ Cancer________________________
  year diagnosed ______________
- ❑ Cancer treatment
  ❑ surgery ❑ chemo ❑ radiation
- ❑ Lymph nodes removed _______

If you would like to fill out a **sensory processing questionnaire**, it is available to download on my website. This can be helpful information for massage therapy guidance if you suspect you have any sensory processing quirks or differences like intolerance to certain types of touch, sound, etc.

Female Clients: Please inform me at each session if you are or may be pregnant, or if you are wearing an IUD, as this may affect your treatment plan. ***Thank you!***

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



On scale 0-10 how would you describe your level of discomfort today?

(0 no pain, 10 = excruciating pain) ________________

What makes it worse? ____

What makes it better? ____

When did this pain/problem start? ____

Are you seeing anyone else for your current complaints? ____________________________

Anything else you want me to know? ______________________________________

____

____

____

Are you currently taking any medication or supplement with the following properties:

- ❑ Immunosuppressants
- ❑ Anticoagulants/ blood thinners
- ❑ Pain relievers
- ❑ Muscle relaxers
- ❑ Opioids
- ❑ Anti-inflammatories
- ❑ Beta- or Calcium channel blockers
- ❑ Diuretics
- ❑ Diabetes medication
- ❑ Steroids
- ❑ Topical creams for pain relief

What is a priority for your sessions? Circle your priority and check all that apply:

- ❑ Stress relief
- ❑ Pain relief
- ❑ Health maintenance
- ❑ Performance improvement
- ❑ Prevention of pain
- ❑ Prevention of injury
- ❑ Prevention of falls
- ❑ Posture improvement
- ❑ Self care / self regulation
- ❑ Other ______________________________

Subjective Self Evaluation:

This short questionnaire provides important information about current quality of life. It will also provide for you a benchmark of where you were before you started treatment.

Through treatment of your body you may observe improvements and shifts in these quality-of-life benchmarks. I en-courage you to answer all questions, but feel free to leave any questions unanswered.

(10 = Highest most Positive, 0 = Lowest most Negative)

General well being (10 = life is great!) __________

Energy level (10 = feel very energized and able to access my energy) __________

Freedom from tension (10 = no tension, completely at ease) __________

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

Freedom from pain (10 = no pain) __________

Sleep (10 = sleeping deeply and plenty) __________

Relationships (10 = I love people around me and they love me) Eating __________

habits (10 = I eat super healthy and just right quantities) __________

Please list any Surgeries, Bone fractures, and other significant Injuries in the notes below. Major

Surgeries & When:

____

____

____

____

Broken bones/Fractures & When:

____

____

____

Trauma/Injuries/Accidents/Concussions & When:

____

____

____

Consent for Therapy & Cancellation Policy

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®, Certified Yoga Instructor, 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 in the amount of full session, I agree to give at least 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)