Name: _____ **Today's Date:** _____

E-mail: _____**Phone:** _____

Address: _____ **City**_____ **ZIP** _____

Pronouns: _____ **Date of birth:** _____

What do you do for living: _____

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%.

Health History: space for details are on next page. Taking your time to remember all the injuries is much appreciated!

❑ 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 condition
❑ 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 _____

Joint and Muscle Issues:
❑ Headaches
❑ TMJ - Jaw pain R L both
❑ Neck _____
❑ Arms _____
❑ Back upper mid lower sacrum
❑ Spine / disc _____
❑ Hip _____
❑ Legs _____
❑ Knee _____
❑ Ankle _____
❑ Foot _____
❑ Muscle cramps
❑ 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 _____

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:
_____
_____
❑ Concussions:
_____
❑ _____
❑ _____

Cancer:
❑ Cancer_____
❑ year of diagnosis: _____
❑ Surgery
❑ Chemotherapy
❑ Radiation
❑ Lymph nodes removed
❑ _____

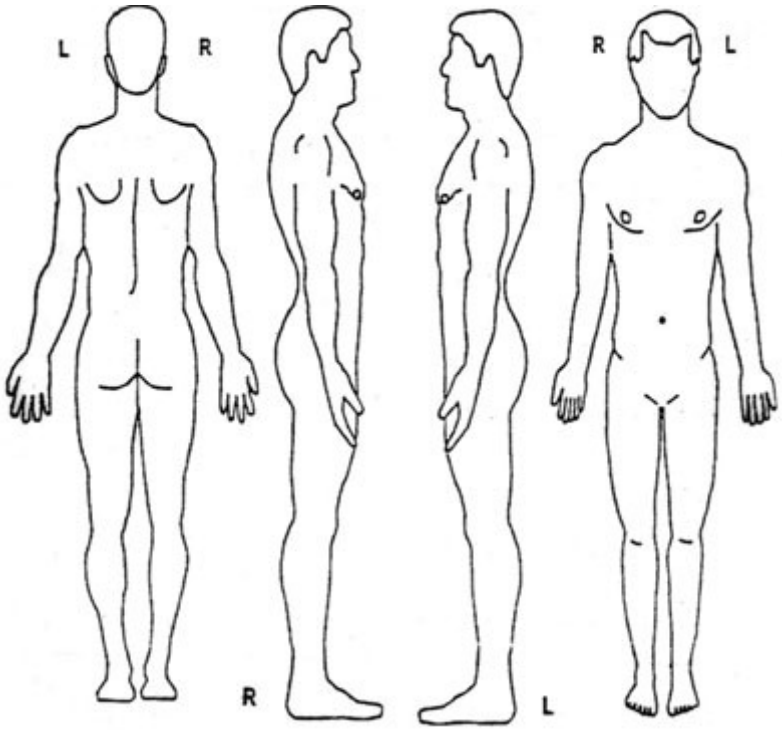
Abdomen and Pelvis:
❑ Poor digestion
❑ Constipation
❑ IBS (Irritable bowel syndrome)
❑ Crohn's disease
❑ Appendix removed
❑ Gallbladder removed
❑ Stones ❑ gallbladder ❑ kidney
❑ Gastro esophageal reflux disease
❑ Diastasis recti
❑ Pain in pelvic area
❑ Hemorrhoids
❑ Hernia _____
❑ Abdominal and/or pelvic surgery

Special senses. Please circle the best answer of sensory perceptions that you experience:

❑ Poor balance and falling	yes	sometimes	very rarely	never
❑ Afraid of heights	yes	sometimes	very rarely	never
❑ Bumping into furniture	yes	sometimes	very rarely	never
❑ Uneasy climbing stairs	yes	sometimes	very rarely	never
❑ I am very attuned and aware of my body	yes	sometimes	very rarely	never
❑ Fabrics bother me	yes	sometimes	very rarely	never
❑ Sensitivity to some types of touch	yes	sometimes	very rarely	never
❑ Sounds and noise bother me	yes	sometimes	very rarely	never
❑ Strong smells bother me	yes	sometimes	very rarely	never
❑ I always wear sunglasses outdoors	yes	sometimes	very rarely	never
❑ I struggle with my sense of taste	yes	sometimes	very rarely	never
❑ I avoid crowds	yes	sometimes	very rarely	never
❑ I struggle walking barefoot	yes	sometimes	very rarely	never
❑ I struggle with my vision	yes	sometimes	very rarely	never
❑ I struggle with my hearing	yes	sometimes	very rarely	never
❑ 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 or discomfort, 10 = excruciating pain or discomfort) ____

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)