**Adult Intake Form**

Cori Escalante, Certified Massage Therapist

Name: _____ Birthdate: _____

Email Address: _____ Age: _____

Phone (Primary): _____ Phone (Secondary): _____

Emergency Contact (Name, Relation, Phone): _____

Whom may we thank for referring you? How did you hear of us? _____

Have you received Craniosacral Therapy? _____ Massage therapy? _____

What is your Primary reason for seeking treatment? _____

If there are other issues or concerns, please list them in order of importance:

1. _____
2. _____
3. _____

Have you been treated before for these issues? If yes, please describe treatment: _____

_____

Concerning the primary issue, when did you first experience signs/symptoms? _____

Did they occur suddenly or gradually? _____ Is it getting progressively worse? _____

Rate the severity of pain from 0 – 10 (0 = none, 10 = most severe pain)

Today _____ Average _____ Worst _____

Is this problem:

☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclical

What is the quality of your symptoms? (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Numb | ☐ Cramping | ☐ Local (one spot) |
| ☐ Achy | ☐ Tingling | ☐ Dull | ☐ Radiates |
| ☐ Throbbing | ☐ Shooting | ☐ Deep | ☐ Other |

How long has it persisted? _____

What makes it worse? (e.g. sitting, walking, bending, etc.) _____

What provides relief? _____

Does it interfere with? (Check all that apply)

| | | |
|---|---|---|
| ☐ Work | ☐ Daily Routine | ☐ Other _____ |
| ☐ Sleeping | ☐ Recreation | |

Please list all injuries, surgeries, procedures, and/or hospital visits with reasons and dates: _____

_____

_____

_____

List any types of health care or medical treatment you are currently receiving: _____

_____

Present prescription drugs: _____

Over the counter drugs (past 6 months): _____

List describe any serious injuries, accidents, or major illnesses: _____

_____

_____

List describe any hospital stays, surgeries, procedures: _____

_____

_____

Do you currently have any of the following conditions?

☐ Scraps, Cuts, Wounds
☐ Cold / Flu / Covid19
☐ Heart Condition
☐ Contagious Disease
☐ Skin Condition
☐ Circulatory Condition

Females – please check the following if they apply.

☐ Pregnant (Weeks) _____
☐ Menstrual cycle issues
☐ Previous pregnancies (How many?) _____
☐ Previous Deliveries (How many?) _____
☐ Episiotomy
☐ Diastasis
☐ Prolapse

Check any of the following conditions you have suffered from:

☐ Chronic Colds
☐ Chronic Pain
☐ Headaches
☐ Back Pain
☐ Knee Pain
☐ TMJ Disorder
☐ Constipation
☐ Digestive Problems
☐ Scoliosis
☐ Asthma / Allergies
☐ ADD/ADHD
☐ Seizures
☐ Dental Issues
☐ Genetic Disorder
☐ Sleeping Issues
☐ Heart Issues
☐ High Blood Pressure
☐ Other: _____

Please explain the above: _____

Anything else I should know? Anything else you'd like to share? Please use the space below to elaborate give any information that may have been missed. (Continue the back if needed)

_____

_____

_____

**CANCELLATIONS AND/OR MISSED APPOINTMENT POLICY**

_____ (initial) I understand cancellations made with less than 24-hour notice, late arrivals, and no-shows are liable for the cost of the full session and will be charged.

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**CONSENT FOR CARE**

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required. Because massage/bodywork may be contraindicated for certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure or work may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand massage therapists and bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session(s) given should be construed as such. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client's Name: _____ Date: _____

Signature: _____