



407-673-6776 office 407-673-2364 facsimile  
450 Lakemont Avenue, Suite A, Winter Park, FL 32792

### Student Clinic Confidential Intake Form

This form must be completely filled out, signed, dated and returned by fax or email, or we will be unable to book your appointment. Fax: **407-673-2364** Email: **clinic@massagetherapy.cc**.

I) Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address: \_\_\_\_\_  Male  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Female  
Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Current Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

II) A. List **ALL** surgeries, injuries, illnesses and accidents with dates, to include all motor vehicle accidents, worker's compensation injuries and falls. **(if none, write "none")**

_____	_____
_____	_____
_____	_____

B. List **ALL** medications, supplements or herbal remedies you are currently taking:  
**(If none, write "none")**

_____	_____
_____	_____
_____	_____
_____	_____

C. What other therapies are you currently receiving?

Physical Therapy     Chiropractic Adjustment     Acupuncture Treatments  
 Other: Describe: \_\_\_\_\_

D. Check all current conditions which apply to you. Check "No" for others:

Yes	No		Yes	No	
___	___	Pregnancy	___	___	Hypertension
___	___	Diabetes: Type_____	___	___	Varicose Veins
___	___	Stroke (CVA, TIA)	___	___	Headaches
___	___	Disc Problems	___	___	Blood Clots
___	___	Bruise Easily	___	___	Osteoporosis
___	___	Cardiac Conditions	Specify:	_____	
___	___	Cancer	Specify:	_____	
___	___	Allergies	Specify:	_____	
___	___	Arthritis	Specify:	_____	

III) Have you ever received a massage therapy treatment before?  Yes  No

IV) Are you presently under the care of a physician?  Yes  No

Physician's name \_\_\_\_\_ Physician's phone: \_\_\_\_\_

What is the diagnosis? \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

V) Are you experiencing discomfort, pain, numbness, tingling, or limited movement?

Yes  No If so, where is the discomfort? \_\_\_\_\_

When did the discomfort begin? \_\_\_\_\_

What activity were you doing when it started? \_\_\_\_\_

Would you describe the discomfort as:  Mild  Moderate  Severe

Do you feel pain anywhere?  Yes  No If yes, where? \_\_\_\_\_

Do you feel pain with movement?  Yes  No If yes, where? \_\_\_\_\_

Do you feel pain with touch?  Yes  No If yes, where? \_\_\_\_\_

Do you feel pain at rest?  Yes  No If yes, where? \_\_\_\_\_

I understand that a student of the Central Florida School of Massage Therapy will provide the massage therapy treatment under the supervision of a Licensed Professional Health Care Practitioner. I release the student, school, and practitioner from any and all liability due to injury or other causes resulting from the treatment. I expressly give permission for the massage session(s) I receive, and I understand that these services are not a substitute for medical care. I have stated all medical conditions of which I am aware, and I will notify the CFSMT Student Clinic of any changes in my health status. You must make your first appointment within **six months**, or this form will be shredded.

**I understand that when I book my first appointment, I will be charged the \$35 fee at that time.**

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Intake Reviewed by:	Date:	Comments: