



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: _____
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: