CENTRAL FLORIDA SCHOOL OF MASSAGE THERAPY

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: