



**COLLECTIVE
HARMONY**
massage & healing arts

Intake Form

Name _____ Date _____

Address _____
Street City State Zip

Date of Birth _____ Home Number _____ Cell Number _____

Emergency Contact _____
Name Relationship Number

E-Mail address: _____ used to confirm appointments and special promotions.

Referred By _____

Are you presently taking any medication? ___Yes ___No

Please Explain: _____

Have you had a recent major surgical procedure or injury? ___ Yes ___ No

Please Explain: _____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

___ Yes ___No Is this part of an insurance claim? ___ Yes ___ No

Please Explain: _____

Please circle your stress level: Low 1 2 3 4 5 High

Are you allergic to any Lotions or Essential Oils? ___ Yes ___ No

Please Explain: _____

Intake Form

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Bulging or herniated disc
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other: _____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Blood clots
Other: _____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other: _____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other: _____

Reproductive System

Pregnancy

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophilia

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Sensitive to Heat
Other: _____

I have read the CAM bill of rights and all information I have provided is complete and accurate.

Client's signature _____ Date _____