Name: _____ **Today's Date:** _____

E-mail: _____**Phone:** _____Mobile/Home

Address: _____ **City**_____ **ZIP** _____

Sex: F M ____ **Date of birth:** _____/_____/_____ **Marital Status:** ❑ Married ❑ Divorced ❑ Single

Occupation: _____ **Referred by:** _____

Emergency Contact: _____ **Relationship:** _____

Phone number: _____

Reason for your appointment:

_____
_____
_____
_____

Do you have any short and/or long term goals that you would like me to help you with?

_____
_____
_____
_____

Check the list of things you are currently doing or have done for yourself to achieve your goals?

Exercise/Movement: _____ How often? _____ x week

Massage/PT/OT: _____ How often? _____ x week

Outdoor Activities: _____ How often? _____ x week

Other: _____ How often? _____ x week

Do you have hobbies, or how do you like to spend your free time?

_____
_____

Please try to remember if you are or were ever able to do any of these things:

1. Can you now or could you ever place your hands flat on the floor without bending your knees? Yes ❑ No ❑
2. Can you now or could you ever bend your thumb to touch your forearm? Yes ❑ No ❑
3. As a child you amuse your friends by contorting into strange shapes OR could you do splits? Yes ❑ No ❑
4. As a child or teenager did your shoulder ever dislocate on more than one occasion? Yes ❑ No ❑
5. Do you consider yourself double jointed? Yes ❑ No ❑

(Adapted from Hakim & Grahame's Five part Questionnaire for identifying hypermobility) Answers in the affirmative to 2 or more questions suggest hyper mobility with sensitivity 80-85% and specificity 80-90%.

Medical History:

This information is gathered to evaluate potential contraindications, precautions, and limitations to therapy.

❑ Recent surgery (< 12 weeks ago)

_____

_____

❑ Past surgery (>12 weeks ago)

_____

_____

_____

_____

_____

_____

❑ Shunt _____

❑ Chemotherapy port

❑ Pacemaker

❑ _____

❑ Herpes _____

❑ Hepatitis (❑ A ❑ B ❑ C)

❑ Skin infection (current)

❑ Psoriasis or eczema

❑ Bruise easily

❑ Swelling _____

❑ Lymphedema

❑ Significant scars _____

_____

Abdomen and Pelvis:

❑ Digestion/GI pain/problems

_____

❑ Constipation

❑ IBS (Irritable bowel syndrome)

❑ Appendix removed

❑ Gallbladder removed

❑ Stones □ gallbladder □ kidney

❑ Acid reflux

❑ Pain in pelvic area

❑ Diastasis Recti

❑ Hernia

Joint and Muscle Problems:

❑ Headaches

❑ TMJ - Jaw pain R L both

❑ Neck _____

❑ Arms _____

❑ Back _____

❑ Herniated disc _____

❑ Hip _____

❑ Legs _____

❑ Knee _____

❑ Foot _____

❑ Muscle cramps

❑ Hypermobility

❑ Shortness of muscles (stiffness)

❑ _____

Women - Pregnancy & Birth:

❑ Currently pregnant

❑ Natural childbirth (No._____)

❑ C-Section births (No. _____)

❑ Delivery complications

❑ Painful periods

❑ Endometriosis

❑ Wearing an IUD

❑ Menopausal (□ Pre □ Post)

❑ Hysterectomy _____

❑ Prolapse _____

Sensory-Motor Questions:

Hand dominance R ❑ L ❑ B ❑

Eye dominance (if known) R ❑ L ❑

❑ Balance issues

❑ Vision issues (Rx, and other)

❑ Hearing issues or sensitivities to noise

❑ Sensitivity to clothing or touch

❑ Smell sensitivities

Other:

❑ Arthritis _____

❑ Osteoporosis

❑ Osteopenia

❑ Diabetes

❑ High blood pressure

❑ Heart problem _____

_____

❑ Numbness or tingling anywhere

_____

❑ Breathing problems _____

❑ Allergies _____

❑ Sinus chronic problems

❑ History of pneumonia/bronchitis

❑ Fibromyalgia

❑ Autoimmune disorder

_____

❑ Stroke - year: _____

❑ _____

Accidents/Injuries:

❑ Injuries _____

_____

_____

❑ Car accidents _____

_____

_____

❑ Concussions How many? _____

❑ Whiplash

Cancer:

❑ Cancer_____

_____

❑ Cancer treatment

□ surgery □ chemo □ radiation

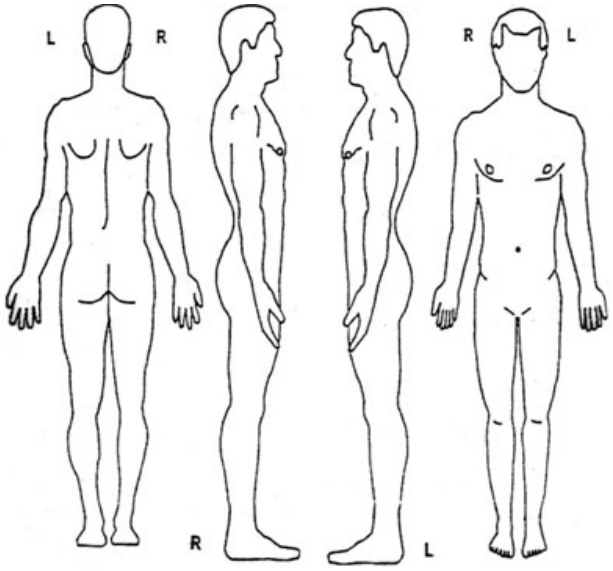
❑ Lymph nodes removed

_____

Female Clients: Please inform me at each session if you are or may be pregnant, or if you are wearing an IUD, as this may affect your treatment plan. ***Thank you!***

Body Map

Please mark areas of concern, pain, numbness, tingling, spasms, etc. in your body.



On scale 0-10 how would you describe your level of discomfort today?

(0 = no pain, 10 = excruciating pain) _____

What makes it worse? _____

What makes it better? _____

When did this pain/problem start? _____

Are you seeing anyone else for your current complaints? _____

Anything else you want me to know? _____

_____

_____

Medications: (Please list important medications you are currently taking)

_____

_____

Supplements: (Vitamins, minerals, herbs you are currently taking)

_____

_____

Subjective Self Evaluation:

This short questionnaire provides important information about current quality of life. It will also provide for you a benchmark of where you were before you started treatment.

Through treatment of your body you may observe improvements and shifts in these quality-of-life benchmarks. I encourage you to answer all questions, but feel free to leave any questions unanswered.

(10 = Highest most Positive, 0 = Lowest most Negative)

General well being (10 = life is great!) _____
Energy level (10 = feel very energized and able to access my energy) _____
Freedom from tension (10 = no tension, completely at ease) _____
Ability to deal with stress (10 = handle stress very well) _____
Freedom from pain (10 = no pain) _____
Sleep (10 = sleeping deeply and plenty) _____
Relationships (10 = I love people around me and they love me) _____
Eating habits (10 = I eat super healthy and just right quantities) _____
Intimacy (10 = I have a very fulfilling relationship with my partner) _____

Please use this space for listing any Surgeries, Bone fractures, and other significant Injuries in the notes below.

Major Surgeries & When:

_____
_____
_____

Broken bones/Fractures & When:

_____
_____

Trauma/Injuries/Accidents/Concussions & When:

_____
_____
_____
_____

Consent for Therapy

Please take a moment to read the following, then sign and date where indicated. If you have a specific medical condition or symptoms, a referral from your primary care doctor may be required prior to your therapy.

I hereby apply and consent to massage therapy from Tjasa Cerovsek Landes (TCL), a Certified Myofascial Therapist, Certified Yamuna body rolling®, Holistic Manual Lymph Drainage Therapist, and a Licensed Massage Therapist in the State of Florida.

I understand that any relief of physical or emotional symptoms is coincidental with alignment and organization of the total human structure, and that alleviation of symptoms is not the primary goal of this therapy approach, rather it is a holistic approach to wellness and health. I understand that results vary from individual to individual and that no specific results can be guaranteed.

I understand that TCL does not treat, diagnose or prescribe for any illness, disease, or any other physical or mental condition. Nothing said or done by the therapist should be construed as such. I understand that the services offered are not a substitute for medical care, and that information provided to me is educational in intent, and **not** diagnostically prescriptive in nature.

I understand that it is necessary for TCL to touch my body in order to provide therapeutic bodywork and massage. I give permission and consent to do all things necessary in helping me establish balance, alignment and relief from my complaints described in this intake form. I know that I am able to and will inform TCL immediately if I experience any pain or discomfort during my session, so that pressure and technique may be adjusted to my level of comfort. I understand that services I receive are strictly therapeutic and non-sexual in intent.

I understand that the information I provide on this form will be confidential, and will be used for no other purpose than treatment protocol and TCL's clinical studies. (A copy of privacy policy is available upon request.) I understand that with my permission and verbal consent my treatment records may be used by the practitioner to consult with other medical providers and specialists in the course of my treatment.

Because massage therapy/bodywork is contraindicated under certain health conditions, I affirm that I have disclosed all known health conditions and answered all questions honestly. I agree to keep the therapist informed as to any changes in my health and my health care, and agree that there shall be no liability on the therapist's part should I not do so.

By signing this form, my consent applies to this session and all subsequent sessions by TCL. I understand that I am financially responsible for my appointments and that payment is due at the time of service.

In order to avoid cancellation charges, I agree to give 24 hours notice of cancellation.

Client: _____ Date: _____

Signature: _____

(Parent or legal guardian's signature, if client is a minor)

Parent's Name: _____

(Parent or legal guardian's name, if client is a minor)