Client Intake Form:

Confidentiality: All information will be held strictly confidential.

We will not sell or share your information with any person or organization without a signed release form.

Name: ______________________ **Birth date:** ______________

Address: ____

City: ______________ **State:** __________ **Zip Code:** __________

Phone number: ______________ **Email:** ______________________

Emergency contact: ______________________ **Phone number:** ______________

How did you hear about us? ______________________________________

Have you received massage before? **Yes** **No** **Have you received Craniosacral Therapy?** **Yes** **No**

Daily activities and exercise? ______________________________________

____

Primary reason for today's visit? ______________________________________

____

____

Health History Questionnaire:

Yes No Do you wear contact lenses?	Yes No Do you wear dentures? Dental Implants?
Yes No Any muscle pain / stiffness?	Yes No Any joint or disc pain / stiffness
Yes No Frequent Headaches / Migraines	Yes No Sleep disturbances?
Yes No High/Low blood pressure?	Yes No Any Heart problems / disease
Yes No Numbness / Tingling / Loss of feeling?	Yes No Cancer / Tumors?
Yes No Any digestive problems	Yes No Arthritis?
Yes No Any skin problems / disease	Yes No Any open sores?
Yes No Allergies?____________________________________	Yes No History of extensive dental work?

Health History:

Surgeries / Hospitalizations?____

____

Accidents / Injuries?____

____

Stress / Anxiety / Depression?____

____

Medications / Supplements?____

____

Are you currently under the care of other healthcare providers (MD, LMT, Naturopath, Acupuncture, Chiropractor)?______________________

____

Any other comments or healthcare concerns?____

____

____

____

____

Please check each box to confirm you have read and understand statements below:

- ☐ **I have provided all my known medical information and will inform my practitioner of any health history changes. It is the client's responsibility to keep the massage therapist updated on any changes to medical history.**
- ☐ **I understand that the therapies offered here are NOT a substitute for a professional medical diagnosis or professional medical treatments. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination.**
- ☐ **Cancellation Policy: We ask that you give us 24 hours prior notice if you need to reschedule or cancel your scheduled appointment. If you are unable to give this notice, we ask that you take responsibility for payment of the visit in full. This does not apply if we are able fill your appointment time with another client or in the case of an emergency.**

I verify that all of the information provided is correct and current to the best of my knowledge.
I hereby give consent to receive treatment (Or, give consent to treat the patient named previously for whom I am legally responsible) from Alissa K Kipp (Oregon License # 18918).

Client Signature:______________________________________ **Date:**____________________