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: ___________________________________________________________

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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______________________