INTAKE FORM Taum Sayers

This serves note our beginning and guide our path forward.

Please print, complete, sign, and bring with you.

First Name _____ Last Name _____ Date of birth _____

Referred by _____

Email Address _____ Mobile Phone # _____

Home Phone # _____ Work Phone # _____

Street Address _____ _____

City_____ State _____Zip Code_____

Emergency contact name _____Physician's name _____

Emergency contact relationship _____

Physician's phone # _____Emergency phone # _____

Date of initial visit _____

How would you rate your general health?

◯ Excellent ◯ Good

◯ Fair ◯ Poor

Have you had a professional massage before?

◯ Yes *(Date of last treatment)* _____

◯ No

Reason for initial visit…where is your body talking to you?

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

List current medications & the conditions they are treating

INTAKE FORM Taum Sayers

HEAD NECK

- ○ Headaches / migraines
- ○ Vertigo / dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Numbness / tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Phlebitis / varicose veins
- ○ Pacemaker
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV / AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes Unexplained
- ○ weight loss
- ○ Digestive conditions
- ○ Fibromyalgia
- ○ Chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Other conditions _____

_____

_____

_____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

I understand:

- That I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis.
- There is no implied or stated guarantee of the success or effectiveness of individual techniques or series of appointments.
- That my personal health information will be collected and all information that I provide will be kept confidential unless required by law.
- I also consent that my medical information may be shared by the various care providers involved in my care and treatment.

I agree to pay for each session. I understand that Taum doesn't bill insurance. Taum can provide a record of sessions for the client to submit for insurance reimbursement. Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature: _____ Date: _____