

Muscle Management® with Taum Sayers: Intake form

This serves to 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

HEAD NECK

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

RESPIRATORY

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

NERVOUS SYSTEM

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

MUSCULOSKELETAL SYSTEM

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

REPRODUCTIVE

- Pregnant
- Gynecological problems
- Given birth

CARDIOVASCULAR

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

SKIN & INFECTIONS

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

OTHER CONDITIONS

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

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.
- That this unique therapy may create soreness and pain.

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.

With any minors, parent or guardian is required to be present during appointment and to enter signature.

Signature: _____ Date: _____