COLORADO SCHOOL OF HEALING ARTS STUDENT/PROFESSIONAL MASSAGE CLINIC
CLIENT INTAKE FORM

Your answers help us to provide better service and will be kept completely confidential. *Print clearly*

NAME_____ HOME # _____ DATE_____

ADDRESS _____ CITY _____ ZIP _____

OCCUPATION_____ WORK # _____ CELL # _____

DOB _____ AGE_____ MARITAL STATUS_____ GENDER_____

EMAIL: _____

Emergency Contact: Name _____ Phone # _____

REASON FOR MASSAGE:_____

Have you ever had a Professional Massage? ☐ Yes No ☐ REFERRED BY: _____

Physician's Name _____ Phone # _____

Please be aware that any of the following conditions/medications require you to bring a physician's note.

Please circle any that you have: Cancer, uncontrolled hypertension, blood clots, complications of diabetes, heart disease, pregnancy complications, recent surgery, recent stroke, taking blood thinners, prescription pain meds, medical marijuana or have any other serious conditions. Comments: _____

Do you currently have **any other medical conditions** (not previously listed)? ☐ Yes No ☐ If yes, please explain: _____

Are you **pregnant**? ☐ Yes No ☐ If pregnant, how many months? _____

Are you currently taking **any other medication**? ☐ Yes No ☐ If yes please list medications and what they are for:_____

_____

Please list any **injuries** you have had in the last 5 years (with dates)

_____

_____

Please list any **surgeries** you have had (with dates)

_____

_____

Additional information you would like to share: _____

_____

I AGREE TO UPDATE THIS FORM WITH ANY NEW HEALTH CONDITIONS OR MEDICATIONS. I HAVE RECEIVED, READ AND UNDERSTAND THE CSHA *NOTICE OF PRIVACY PRACTICES.* I UNDERSTAND THAT I MAY CHOOSE TO RECEIVE A MASSAGE IN A STUDENT CLINIC FROM A STUDENT THERAPIST. IF I SO CHOOSE, I FURTHER UNDERSTAND THAT AS A TEACHING CLINIC, THE CLINIC SUPERVISOR MAY BE ENTERING THE ROOM AT THE DISCRETION OF THE STUDENT THERAPIST OR SUPERVISOR FOR EDUCATIONAL PURPOSES TO SUPERVISE THE STUDENT THERAPIST AND DEMONSTRATE ON ME. WHETHER I AM ATTENDING THE STUDENT OR THE PROFESSIONAL CLINIC, I AGREE NOT TO HOLD THE SCHOOL OR THE THERAPIST RESPONSIBLE FOR ANY INJURIES, ACCIDENTS, COMMUNICATION DIFFERENCES, CONFLICTS OR PHYSICAL ILLNESS THAT MAY ARISE DURING TREATMENT. I AGREE TO ABIDE BY THE CLIENT RESPONSIBILITIES FOR STUDENT / PROFESSIONAL CLINIC. **I AGREE TO LEAVE THE TREATMENT ROOM WITHIN 15 MINUTES OF THE END OF MY SESSION AND IF I DO NOT, STAFF WILL KNOCK AND ENTER.**

SIGNED _____ DATE _____