**COLORADO SCHOOL OF HEALING ARTS STUDENT MASSAGE CLINIC**
**CLIENT INTAKE FORM**

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

NAME_____ OCCUPATION_____

ADDRESS _____ CITY / STATE_____ZIP_____

CELL #_____WORK #_____LANDLINE # _____

EMAIL_____DOB_____AGE_____ GENDER/pronouns_____

Emergency Contact: Name _____ Phone # _____

REASON FOR MASSAGE:_____

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

Physician's Name (optional)_____ Phone # _____

**NOTE: Any of the following conditions/medications may 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, Post COVID symptoms or any other serious condition. Comments: _____

_____

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

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

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

_____

List any **injuries** you have had - last 5 years (with dates)

_____

_____

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 AM RECEIVING A MASSAGE IN A STUDENT CLINIC FROM A STUDENT THERAPIST. I FURTHER UNDERSTAND THAT AS A TEACHING CLINIC, THE CLINIC SUPERVISOR MAY BE ENTERING THE ROOM FOR EDUCATIONAL PURPOSES TO SUPERVISE THE STUDENT THERAPIST AND MAY DEMONSTRATE ON ME. I AGREE TO NOT 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 CLINIC. **I AGREE TO LEAVE THE TREATMENT ROOM WITHIN 15 MINUTES OF THE END OF MY SESSION AND I UNDERSTAND THAT IF I DO NOT, STAFF WILL KNOCK AND ENTER.**

SIGNED _____ DATE _____