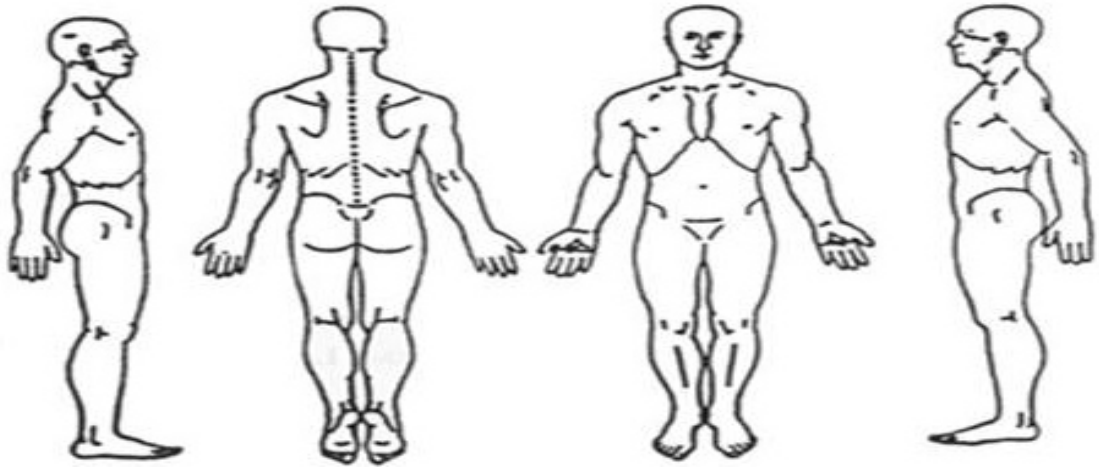
Intake Form

First Name:_____Last Name:_____ DOB:_____
Address:_____City:_____
State:_____Zip:_____
Cell Phone: (_____)_____Work/Home Phone: (_____)_____
Emergency Contact:_____Emergency Contact #: (_____)_____
How did you hear about us? _____

Current Pain

Where is your current pain?



What are you experiencing? (For example: stabbing, burning, electricity, numbness)

How do you think it started?

Did it start acutely or grow slowly with time?

Do you believe it is related to any other process occurring in your body? (For example: back pain related to you pancreatitis, or developed shoulder pain directly after a hip or low back issue)

Medical History
Allergies:

Current medications:
_____
_____
_____
Blood thinners: Y or N Blood pressure medications: Y or N

Please list all surgeries with correlating dates (including C-section, Organ removal, implants, stents, rods, fusions, and cosmetic):
_____
_____
_____
_____

Please list all injections with correlating dates (including steroids, stem cells, PRP, and lidocaine):_____
_____
_____

Please describe your current healthcare team, including PCP, chiropractors, holistic practitioners, specialists, acupuncturists, energy healers, physical therapists, and anyone else you see regularly that keeps you on your path to wellness. (I don't need to know who they are, just what other therapies you are doing and how often).
_____
_____
_____

Activities of Daily Life

Do you exercise? If so, what do you do, and how often?

What are your daily tasks of living? (For example: cooking, cleaning, driving)

What is your profession, and what does it demand of you physically? (Fore example: desk work, regular travel, bicycle tour guide)

What are your hobbies?

Please check all that apply:

__ Cancer
__ Melanomas
__ HIV/AIDS
__ Hepatitis
__ MS
__ Shingles
__Diabetes
__ Neuropathy
__ Anemia
__ Pregnant
__ Pancreatitis
__ Epilepsy
__ Crohn's
__ Necrosis
__ PTSD
__ Alcoholism
__ Arthritis (RA or osteo)
__ Thyroid disease
__ Headaches/ migraines
__ Coordination issues
__ Herpes/ cold sores
__ Skin rash, eczema, psoriasis
__ Contagious skin disease, warts
__ Scoliosis, kyphosis, lordosis
__ Plantar Fasciitis
__ Low blood Pressure
__ High blood pressure
__ Osteoporosis/osteopenia
__ Difficulty taking a deep breath
__ Autism
__ Schizophrenia
__ Substance Abuse
__ Lyme Disease
__ Mold Exposure
__ Fatigue
__ Brain fog
__ Parasites
__ Fungal infection
__ Bacterial infection
__ Asthma
__ Anxiety
__ TMJ
__ Carpal Tunnel
__ Thoracic Outlet
__ Depression
__ ADHD
__ Bipolar Disorder

On a scale of 1 to 10, how much effort are you willing to put towards healing 100%?
1 2 3 4 5 6 7 8 9 10

Do you believe it's possible to heal 100%? Y or N

Once you've healed from your current pain, how will it impact your life? What becomes possible?

_____
_____
_____
_____

What is your goal for today's specific session?

Informed Consent

I, _____ have chosen to consult with and hereby give consent for massage therapy to be provided by the therapist, who I understand is a licensed Massage Therapist.

I have provided a detailed medical history including charts and medications that would affect my therapy, along with any other notable medical factors that would aid in my therapist's knowledge of my medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned, and I understand that massage may provide benefits for certain conditions but results are not guaranteed. **Treatment cannot be performed due to certain conditions (Burns, New surgery, Acute inflammation, open sores or wounds, contagious diseases or viruses) or if the patient is under the influence of substances that would hinder the patient from acknowledging fully the massage being performed.**

Benefits of our session may include manual manipulation of the human body that can fix chronic issues and relieve muscular tension which may also give the patient a better range of motion. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and lightheadedness amongst other possible temporary outcomes. I am aware that the therapist does not diagnose illnesses or prescribe medications, but can recommend an appropriate practitioner to aid the patient in furthering their well being. **I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.**

The privacy of our patients along with their health and well being are of the utmost importance. All information given is securely filed and preserved for the patient and the patient alone unless otherwise noted by the patient. Under no circumstances should any of our clients information will be given to any 3rd party without the express written consent of the client.

If you have read and agree to the above please sign and date below:

Client Signature (or Guardian's): _____

Date_____

Kodawari Cancellation Policy:

If an appointment is cancelled within less than 24 hours of said appointment, 50% of the appointment will automatically be charged to the card on file.

If an appointment is cancelled within less than 8 hours of said appointment *for any reason*, the appointment will be charged at full price.

Client Signature (or Guardian's): _____

Date_____

External Affairs:

Any tasks or communications performed outside of your appointment time, be it with doctors, lawyers, or insurance companies, will be charged in 15 minutes increments at the same rate as your appointment. Often specific formats for treatments notes need to be compiled for insurance companies, or detailed explanations of treatment need to be written; as this takes the practitioners a great deal of time, it will be compensated as such.

Client Signature (or Guardian's): _____

Date_____