Catie Rasmussen, LMT
106 N Church Street, 2nd floor
Boalsburg, PA 16827
www.RootsofSpace.com
814.321.8221

Confidential Intake Form

Name _____ Date _____ Phone _____
Email _____ Date of Birth _____
Address _____City _____
State _____ Zip _____ Occupation _____
Emergency Contact _____ Phone _____

Please answer the questions to the best of your knowledge.

- Have you had a professional massage before? Yes __ No __
  If yes, how often do you receive massage therapy/what type? _____
- Do you have any difficulty lying on your front, back, or side? Yes __ No __
  If yes, please explain _____
- Do you have any allergies to oils, lotions, or ointments? Yes __ No __
  If yes, please explain _____
- Do you have sensitive skin? Yes __ No __
- Are you wearing: contact lenses__ dentures__ hearing aids__?
- Do you sit for long hours at a workstation, computer, or driving? Yes __ No __
  If yes, please describe _____
- Do you perform any repetitive movement in your work, sports, or hobby? Yes __ No __
  If yes, please describe _____
- Do you experience stress in your work, family, or other aspect of your life? Yes __ No __
  If yes, how do you think it has affected your health?
  Muscle tension __ anxiety __ insomnia __ irritability __ other _____
- What are your goals for this session? _____

Medical History

- Are you currently under medical supervision? Yes __ No __
  If yes, please explain _____
- Do you see a chiropractor? Yes __ No __ If yes, how often? _____
- Please check any condition listed below that applies to you:

☐ skin condition	☐ chronic pain	☐ TMJ
☐ open sores or wounds	☐ back/neck problems	☐ ADD/ADHD
☐ easy bruising	☐ constipation/diarrhea/IBS	☐ cancer
☐ whiplash	☐ braces/orthodontia	☐ diabetes
☐ recent accident or injury	☐ osteoporosis	☐ swollen glands
☐ recent surgery	☐ epilepsy/seizures	☐ diabetes
☐ artificial joint	☐ headaches/migraines	☐ sprains/strains
☐ depression	☐ chemical dependency (alcohol, drugs)	☐ broken bones
☐ bipolar/other psych disorder	☐ concussion, head trauma	☐ scoliosis
☐ anxiety/panic attacks	☐ allergies/sensitivity	☐ insomnia
☐ heart condition	☐ carpal tunnel syndrome/tennis elbow	
☐ high or low blood pressure	☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis	
☐ circulatory disorder	☐ physical, mental, emotional, or sexual abuse	
☐ varicose veins	☐ decreased sensation/neuropathy	
☐ deep vein thrombosis/blood clots	☐ pregnancy	
☐ stroke	☐ infertility or pregnancy loss	

☐ auto-immune condition (AIDS, chronic fatigue, fibromyalgia, lupus, etc.)

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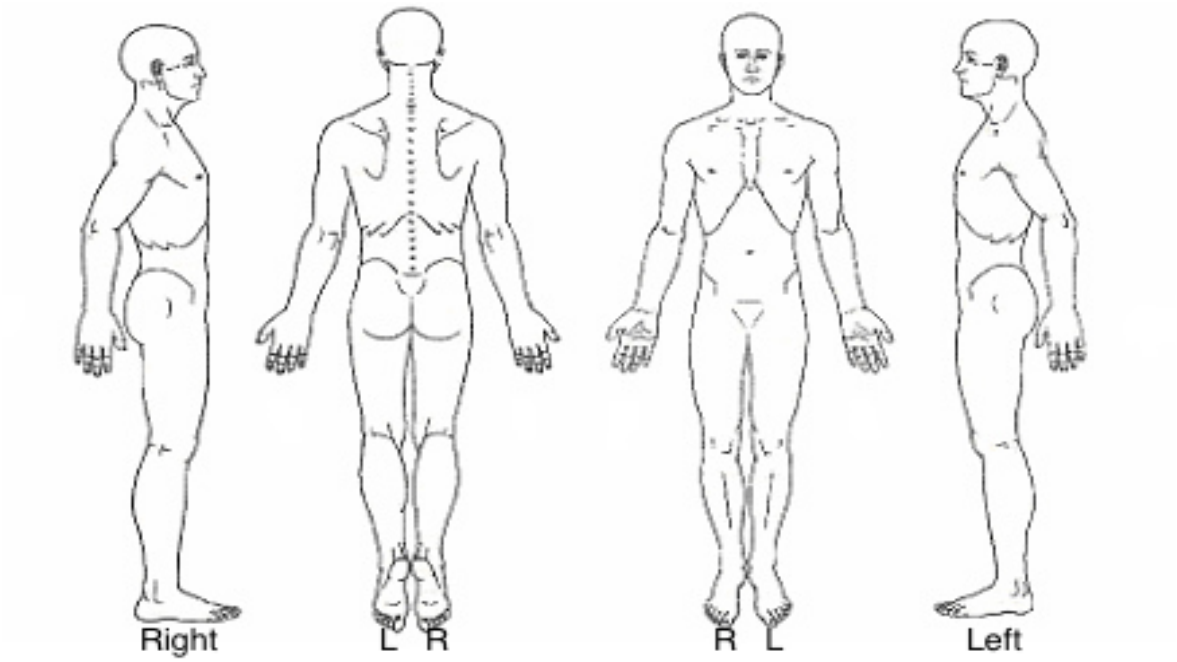
Please explain any condition that you have marked above _____
_____
Is there anything else about your health history that you think would be useful for me to know to plan a safe and effective session for you? _____
Are you currently taking any medication or supplements? Yes __ No __ If yes, please list _____
_____
_____

Circle any specific areas that you feel pain or discomfort



The following sometimes occurs during bodywork. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position ❖ sighing, yawning, change in breathing stomach gurgling ❖ emotional feelings ❖ expression of movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories ❖ dream-like state.

Please read the following information and sign below:

- I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.
- I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.
- I understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage/bodywork is contraindicated.
- Informed written consent must be provided by parent or legal guardian for any client under the age 17.

Signature of client _____ Date _____