

Massage | Craniosacral | Cupping
Intake Form

Date: _____

Name: _____

What do you like to be called: _____

Date of Birth: _____ Age: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____

Phone Number (____) _____ (____) _____ (____) _____
Home Cell Work

E-Mail Address: _____

Occupation: _____ SS#: _____

How did you hear about me? _____

Friend/Family(who) _____ Healthcare Provider: _____

Internet: _____ Yellow Pages: _____ Other: _____

Please list all medical conditions you have _____

Please list all medications that you take _____

Drug Allergies: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

By signing this form I give my consent to receive a massage, craniosacral, and/or cupping treatment. I understand I may discontinue the session at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. Information may be shared among practitioners at Synergy. I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status.

Signature: _____ Date: _____

Synergy Holistic Health Center

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(859) 525-5000 | www.synergyholistichealth.com

Please mark if you have had any of these conditions *(please include the date that the condition occurred)*

_____ Broken Bones	_____ Kidney disease
_____ Epilepsy	_____ Hepatitis
_____ High/Low Blood Pressure	_____ Headaches
_____ Diabetes	_____ Numbness in Extremities
_____ Heart Disease	_____ Respiratory Disorders
_____ Arthritis/Osteoporosis	_____ Fatigue
_____ Back Pain/Problems	_____ Anxiety
_____ Allergies/Sinus Problems	_____ Neck Pain/Problems
_____ Mood Swings	_____ Tuberculosis
_____ Thyroid Disorders	_____ Aneurysm
_____ Phebitis (blood clots)	_____ Skin condition
_____ Cancer Type	
_____ Aids/HIV Treatment	
_____ Pregnant Due Date	

Please list any surgeries (within the last 2 years) _____

What brings you here today? _____

Have you ever had a professional massage? Do you prefer a lighter touch or deep tissue? _____

Please circle problem areas.

