Synergy Holistic Health Center
7309 US Hwy 42, Suite A, Top Floor, Florence, KY 41042
(859) 525-5000 | www.synergyholistichealth.com

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:____________

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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) ____

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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.