CONFIDENTIAL INTAKE

Barrie L. Robbins, CTP, LMT #17639

1. **Please email/text PROOF OF COVID-19 VACCINATION.**
2. **Masks are required for entire duration of session.**
3. **Please print, complete, and bring this form with you.**

Please print

Name _____

Phone _____

Date of Birth _____Age _____

Gender or Pronouns: _____

Street _____

City _____ State _____ Zip _____

email address _____

referred by _____

Current health status:

☐ fever
☐ inflammation
☐ severe pain
☐ cuts, burns, bruises
☐ irritated skin rash
☐ cold or flu
☐ contagious condition

other _____

Are you under the care of a physician?

☐No ☐ Yes If yes, for what condition(s)?

_____

Current medications/For what?

_____
_____
_____
_____

Have you had and major illnesses, chronic conditions, injuries, accidents, psychiatric care?

_____
_____
_____

Current therapies and past bodywork experience:

_____
_____
_____
_____

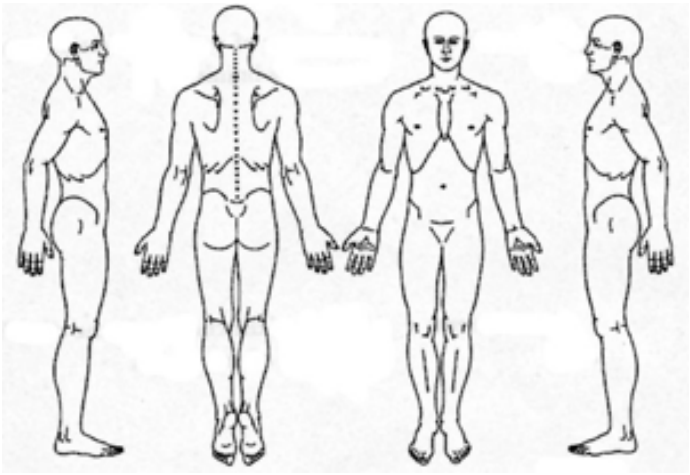
Current activities: type/frequency:

_____
_____
_____
_____

Allergies:

_____

Please indicate where you feel discomfort (X) and where you feel most open (O)



Please read, initial, and sign below:

____ I understand that massage is not a replacement for medical care and that no diagnosis will be made.

____ I am responsible for paying for any appointment cancellation of less than 24 hrs.

Signature_____

Date _____