CURA Holistic Health and Massage Center

4949 Tamiami Tr. N, Suite 107, Naples, FL 34103
TEOFIL NIKOLOV, BS, LMT, CKTP
Phone: (239) - 450 - 4325
FeelHealed.com
MA 28362

Confidential INTAKE Form

We promise not to over-email or misuse your info

Name_____

Address_____

City_____ State_____ Zip_____

Phones: Home (____) _____ Mobile (____) _____

e-mail: _____ preferred contact/confirmation method: □e-mail □ mobile

Date of birth_____ Sex: □M □ F Marital status: _____

Occupation: _____

Emergency contact: _____Relationship:_____Phone_____

Referred by: _____

Please list any surgeries in the last 5 years _____

_____

Please list any medications currently using _____

_____

Are you taking any nutritional supplements? □Yes □ No If yes, please list:_____

List any allergies and reactions to these_____

Activities/Exercise: □ Never □ Light □Moderate □Heavy . **Are you pregnant: □Yes □No Due date: _____**

Reason for appointment (Major complaint)_____

Describe results from previous bodywork for this condition if any _____

Is there anything that makes the condition worse? _____

_____

Please continue on reverse side ..... →→→

Please "check mark" the following conditions that apply to you:

General:

____HEADACHES
____INSOMNIA
____DIZZINESS
____FAINTING SPELLS
____SEIZURES
____FATIGUE
____DEPRESSION
____ENLARGED THYROID
____BLURRIED / DOUBLE VISION
____CRAMPS
____LOSS OF BALANCE
____EARS RINGING / POPPING
____CONTAGEOUS DISEASE
____CANCER (ANY TYPE)

Genito-Urinary:

____HYSTERECTOMY
____KIDNEY INFECTION
____KIDNEY STONES
____KIDNEY FAILURE
____NEPHRITIS
____PAINFUL URINATION
____PROSTATE TROUBLE

Respiratory:

____SHORTNESS OF BREATH
____ CHRONIC COUGH
____VOMITING BLOOD
____EMPHYSEMA
____BRONCHITIS
____ASTHMA (WEEZING)
____ SINUSITIS
____TUBERCULOSIS

Muscle / Joint:

____ARTHRITIS
____BURSITIS
____BACK PAIN
____NECK PAIN
____SPRAINS
____SWOLEN JOINTS
____NUMBING LIMBS
____HERNIATED DISC
____BROKEN BONES
____SCIATICA PAIN
____ROTATOR CUFF PAIN
____JOINT REPLACEMENT
____OTHER_____

Skin:

____OPEN WOUNDS
____ SKIN PROBLEMS
____BRUISE EASY
____DRYNESS
____FUNGUS
____ITCHING / BURN
____RASH
____CYSTS

Cardiovascular:

____HEART PROBLEMS
____HIGH BLOOD PRESSURE
____LOW BLOOD PRESSURE
____COLD HANDS
____COLD FEET
____VARICOSE VEINS
____PHLEBITIS
____EDEMA
____STROKE
____ANGINA
____RAPID HEART BEAT
____IRREGULAR HEART BEAT
____C. N. G. HEART FAILURE

Gastro intestinal:

____ABDOMINAL HERNIA
____COLITIS
____CONSTIPATION
____DIARRHEA
____CROHN'S DISEASE
____DIABETES
____HYPOGLYCEMIA
____ULCERATIVE COLITIS
____DIVERTICULITIS
____DIVERTICULOSIS

Other (Please explain)_____

_____

_____

_____

_____

_____

Please take a moment to carefully read this information:

If you have a specific medical condition or symptoms, massage may be CONTRAINDICATED. Referral from your primary care provider may be requested prior to treatment being provided. I understand the benefits and risks of massage therapy and give my consent for treatment. I have stated all medical conditions that I am aware of and will keep my practitioner informed of future changes. Therapist reserves the right to REFUSE or DISCONTINUE treatment according to contraindications, noncompliance with ethical codes, or sexual misconduct. Your appointments are very important to us. If you are not feeling well text/call us immediately.Time allocated for an appointment is reserved especially for you. We understand that sometimes schedule adjustments are necessary. We respectfully request at least 24 hour notice for adjustments to your appointments and for cancellations. Notification given less than 24 hour prior to appointment time will result in a 100% service list fee. In addition, House call appointments can be charged 100% of the service plus travel fee if cancelled 12hours prior to House Appointment. I agree to the policies outlined above.

Signature of Client/Patient _____ Date_____