Manual Medicine
advanced therapeutics in healing

INTAKE INFORMATION

Name: ____________________ Current Age: ________ Date: ________

Address:

____
(street)

____
(city) (state) (zip)

Phone: (home)____________________ (work/cell)____________________

Email Address: ____________________

☛ **Please complete the following information in detail. This will assist me in designing the most effective and efficient individualized program for you. Thank you for your effort.**

Who referred you? ____________________

Official Diagnosis/Reason for Visit:

____

____

Please list the main complaints/challenges you have in order of their importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Occupation:

____

If you are currently not working due to pain/illness, how long have you not worked? ____________________

How many hours do you sleep at night? ____________

How would you consider your present level of activity? ____poor ____fair ____good ____excellent

Please list activities you do:

____

____

Are you seeing any doctors or health care professionals for any reason? (Note: These practitioners will not be contacted without your permission.)

Practitioner's Name	Type of Practitioner	Phone Number
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

☛ A goal list will help me recognize what you would like to accomplish. Goals will be revised as needed.

The following are examples provided to assist you in your answer.
I know I will be better when I can:
Example 1: Walk independently for 15 minutes with no pain.
Example 2: Work using just a splint for a half day with occasional pain.
Example 3: Sit at the computer without any pain for one hour.
Example 4: Play a game of tennis without pain in my back.

Please list five statements that finish the statement: **"I know I will be better when I can…"**

1. ____
2. ____
3. ____
4. ____
5. ____

List trauma/accidents (old and new) and when each occurred: ______________________________

____

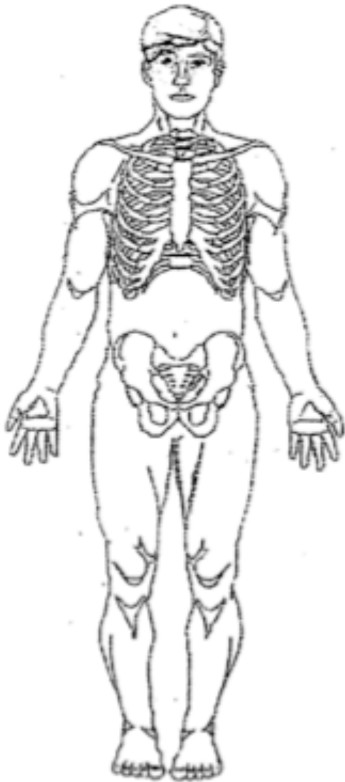
____

List any operations or hospitalizations: ______________________________

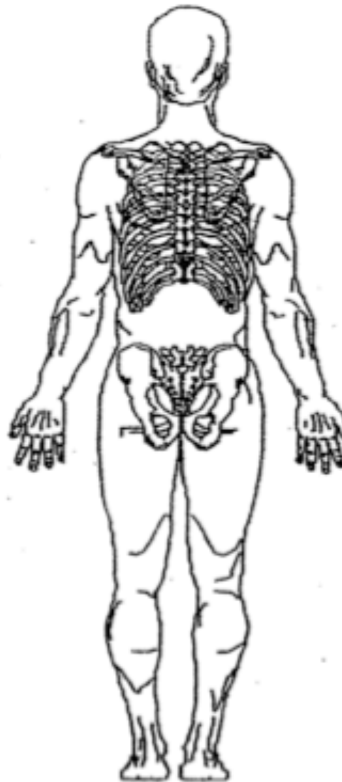
____

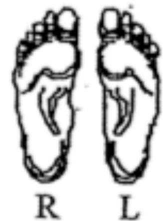
Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

Front



Back





Right Side

Left Side

Alexandra Kaufman, MA, CMT#7585, IMTC, NCBTMB
145 View Ct.
Aptos, CA 95003
(510) 908-9448

Letter of Understanding

Payment and cancellations

I understand that payment in full is due upon completion of each session, unless negotiated otherwise with Alexandra Kaufman (Manual Medicine). For cancellations, I understand that I need to allow at least 24 hours of notification so as to not incur the full amount charged for the session missed.

Results not guaranteed

I understand that Alexandra Kaufman is a State and Nationally licensed massage therapist and bodyworker though not a nutritionist, or doctor of any kind and can not make a medical diagnosis. The services in nutrition are alternative or complementary to healing arts.

I understand that every effort is made to accurately represent the bodywork and its potential, and that there is no guarantee that I will recover from an injury or particular health issue with these techniques. I understand that all bodywork practiced here is for the sole purpose of optimal health and is not intended to provide any official medical diagnostic advise. Information given to me during the session is considered supplemental to any other information provided by my primary care provider. I am encouraged to confer with my doctor about any critical medical situation. Bodywork given is not to be interpreted as a promise or guarantee of recovery. I understand that Alexandra Kaufman does not purport any guarantees of healing. I also understand that past performance of better health through receiving these modalities of bodywork does not insure future results.

____ ____________________

Signature Date