Client Intake Form

Date of Initial Visit: _____

Name: _____ Date of Birth: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

Primary Physician: _____Physician Phone: _____

Occupation: _____Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____Phone: _____

Medical Information

Reason for initial visit: _____

_____

Height & Weight: _____

Are you currently pregnant? ☐ Yes ☐ No

Any high risk factors? _____

Are you taking any medications?

If yes, please list name and use: _____

_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list known allergies _____

_____

Are you experiencing any discomfort, pain, tension or stiffness?
☐ Yes ☐ No If yes, please explain _____

_____

Do you perform repetitive movements in your everyday activity? ☐ Yes ☐ No If yes, please explain _____

_____

Have you recently had any injuries, areas of inflammation or surgeries? ☐ Yes ☐ No If yes, please explain _____

_____

Do you experience stress in aspects of your life? ☐ Yes ☐ No
If yes, please explain _____

_____

Please list all forms and frequency of stress reduction activities, hobbies, exercise, or sports participation

_____

Do you sit for long hours while driving or at a computer workstation? ☐ Yes ☐ No If yes, please explain

_____

Health History

☐ Fatigue
☐ Tension, stress
☐ Sleep difficulties
☐ Chronic pain
☐ Headaches, migraines
☐ Vision problems
☐ Hearing problems
☐ Shingles
☐ Pinched Nerve
☐ Parkinson's disease
☐ Multiple Sclerosis
☐ Shingles
☐ Numbness/Tingling
☐ Paralysis
☐ Ovarian/Menstrual Problems
☐ Prostate issues
☐ Sinus Problems
☐ High/Low Blood Pressure
☐ Diabetes
☐ Joint Replacement(s)
☐ Neuropathy
☐ Sprains or Strains
☐ Heart Attack
☐ Heart Conditions
☐ Stroke
☐ Fibromyalgia
☐ Stroke
☐ Kidney Dysfunction

☐ Blood Clots
☐ Arthritis
☐ Jaw Pain (TMJ)
☐ Lupus
☐ Bone or Joint Disease
☐ Spinal Problems
☐ Phlebitis/Varicose Veins
☐ Thrombosis/Embolism
☐ Blood Clots
☐ Lymphedema
☐ Breathing Difficulty/Asthma
☐ Allergies
☐ Rashes
☐ Fatigue
☐ Colitis
☐ Cosmetic Surgery
☐ Athletes Foot
☐ Herpes/ Cold Sores
☐ Depressions
☐ Anxiety/Stress Issues
☐ Drug/Alcohol/Tobacco Use
☐ Dentures
☐ Hearing Aids

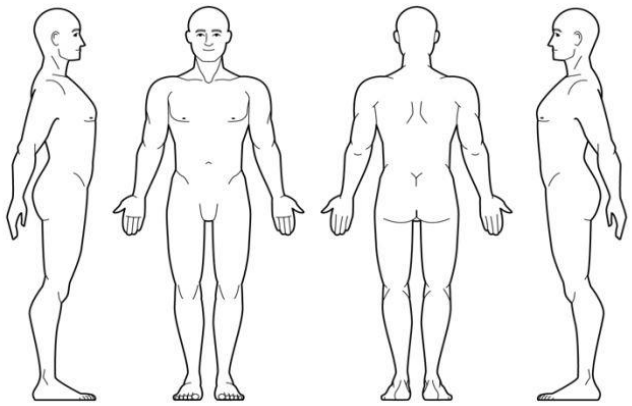
Any other medical condition(s) not listed:

_____

_____

_____

Please circle any areas of discomfort.



Massage Information

Have you had a professional massage before? ☐ Yes ☐ No

How long have you been receiving massage therapy? _____

_____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No If yes, please explain_____

_____

What are your goals for this treatment? _____

_____

_____

Insurance Information

Client's Full Name: _____

Insured's Full Name:_____

Insured's Date of Birth: _____

Insurance ID#:_____

Insured's Employer: _____

Date of injury: _____

Contract for Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge. I authorize and direct payment of medical benefits to my massage therapist, for services billed.

Signature: _____ Date: _____

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the Federation of State Massage Therapy Boards has provided this form as a reference and is not held liable for any services provided.

Signature: _____ Date: _____

Assignment of Benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance. I authorize and direct payment of medical benefits to my massage therapist, for services billed.

Signature: _____ Date: _____

Release of Medical Records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

Signature: _____ Date: _____