MidMichigan
THERAPEUTIC MASSAGE CARE
Improving the quality of living. One person at a time.™
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NEW PATIENT INTAKE FORM

Confidential Information

PRINT BUTTON **Please complete this form then PRINT & SIGN.** RESET FORM

PERSONAL INFORMATION

TODAY'S DATE:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Emergency Contact: _____ Relationship: _____

Phone (Home): _____ Work: _____ Cell: _____

Referred by: _____

CURRENT HEALTH:

Have you received massage therapy before? ☐ Yes ☐ No Frequency: _____

Type of Massage received? ☐ Deep Tissue ☐ Swedish ☐ Therapeutic ☐ Sports ☐ Other

Reason for today's visit: _____

Desired result of today's session: _____

Have you received treatment for this before? ☐ Yes ☐ No

Explain: _____

List Activities Affected: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Current Medications/Herbs/
OTC Remedies: _____

List areas of tension, stress and/or pain you wish to be addressed _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (PLEASE MARK APPLICABLE ONES)

- ☐ Accident
- ☐ Neck Pain
- ☐ Whiplash
- ☐ Headaches
- ☐ Dizziness
- ☐ Anxiety
- ☐ Depression
- ☐ Disc Problems
- ☐ Broken Bones
- ☐ Arthritis / Bursitis/Gout
- ☐ Rash
- ☐ Hepatitis
- ☐ Recent Injury or Trauma
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Joint Ache
- ☐ Decreased Range of Motion
- ☐ Sprains
- ☐ Epilepsy / Seizures
- ☐ Abdominal Pain
- ☐ Nervous Tension
- ☐ Surgery
- ☐ Wear Contacts
- ☐ Edema
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Implants / Prosthetics
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Heart Conditions
- ☐ Cancer
- ☐ Colitis
- ☐ HIV/AIDS

Explain: _____

ALLERGIES OR SENSITIVITIES

☐ Oils ☐ Lotions ☐ Scents ☐ Detergents ☐ Foods ☐ Other:

Explain: _____

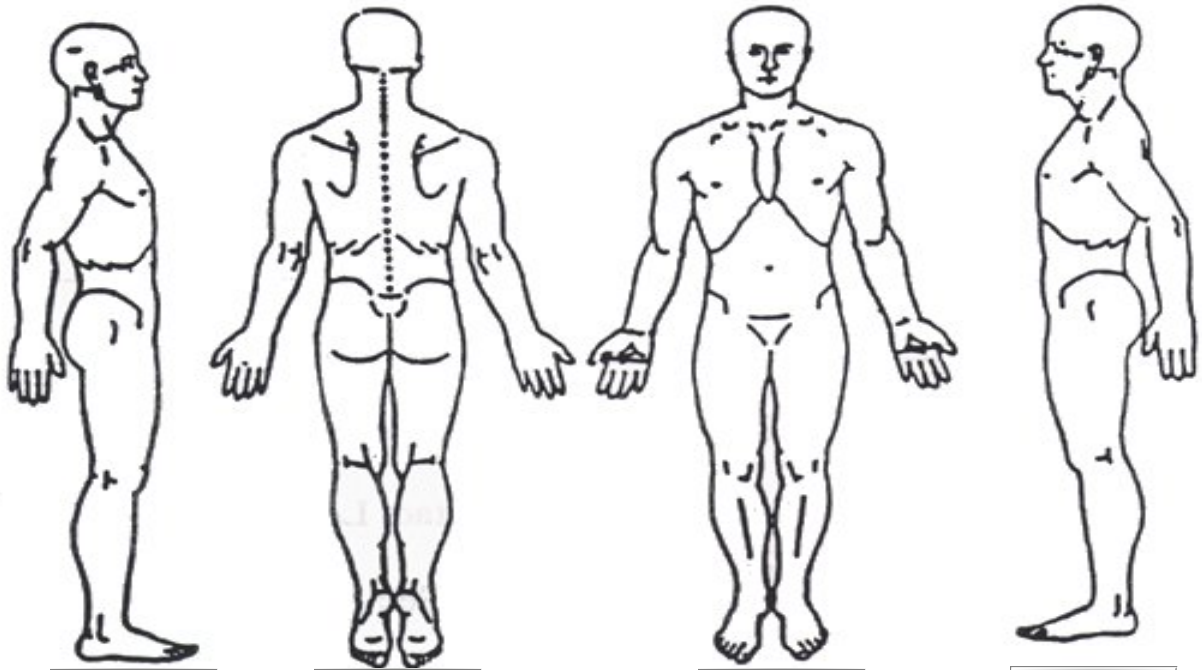
DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ Pregnancy: If so, How far along are you? _____ Due Date:

- ☐ Inflammation
- ☐ Severe Pain
- ☐ Skin Rash
- ☐ Open Cuts / Bruises / Burns
- ☐ Headache
- ☐ Cold / Flu
- ☐ Sunburn / Poison Ivy

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P = Pain or Tenderness S = Joint or Muscle Stiffness N = Numbness or Tingling



RIGHT BACK FRONT LEFT

INFORMED CONSENT AND CONSENT FOR THERAPY

I, _____, understand that:

The relationship between the client/patient and the therapist is a confidential one and that all information provided to the therapist is to be kept confidential. If a referral to another health care practitioner is required I agree to sign an 'AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION' form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of the federal government, U.S. Judicature Act. We strongly encourage you to read and comprehend the HIPAA rule, as it applies to you, which is availed to you at the U.S. Department of Health and Human Services website (www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/); further, by signing this Informed and Treatment Consent you are affirming to have read and understand the HIPAA rule, accordingly.

My massage therapist is both a certified (by an accredited and qualified institution in the U.S.) and a licensed healthcare practitioner within the State of Michigan by Michigan Department of Licensing and Regulatory Affairs, Health Professional Licensing. For more information on the State of Michigan health professional licensure please visit www.michigan.gov/healthlicense.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist **if** anything changes in my status. I understand that massage treatment I receive is for the purpose stated herein, my massage therapy treatment plan. I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers. **If** I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. **If** I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated and shall be handled as a criminal act in accordance with pertinent legal criminal and civil laws. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

I, _____, have read and understand the information contained in this form and consent to be treated for conditions discussed with the therapist today. I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Date: _____

Patient/Client Signature: _____

Therapist: _____