MASSAGE LA MESA
Medical & Sports Massage Therapy

Health Information/Client Intake

Name_____ Date of birth_____

Address _____ City _____ State ____ Zip_____

Phone (_____) _____ Email _____

Would you like to receive our monthly Newsletter? ☐ Yes ☐ No

Referred by _____

Emergency contact _____ Phone (_____) _____

Occupation _____

Have you ever received professional massage/bodywork before? (please circle) Yes No

What kind of pressure do you prefer? Light Medium Firm

List your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.)

_____

Do these symptoms interfere with your activities of daily living (sleep, exercise, work, childcare)

If yes, explain: _____

List the medications you currently take: _____

_____

Please list any treatments you have been receiving to address your health conditions:
(surgeries in past 4 yrs, chiropractic, acupuncture, herbal treatments, nutritionist)

_____

Circle any of the following health conditions that you currently have:
(Massage may not be indicated for these conditions)

Blood clots	Infections	Congestive heart failure
Contagious diseases	Pitted edema	

Please indicate conditions that you have or have had in the past. Include treatment received:

Current Past Muscle or joint pain
Current Past Numbness or tingling
Current Past Swelling
Current Past Bruise easily
Current Past Sensitive to touch/pressure
Current Past High/low blood pressure
Current Past Stroke, heart attack
Current Past Varicose veins
Current Past Shortness of breath, asthma
Current Past Cancer
Current Past Neurological (MS, Parkinson's, chronic pain)
Current Past Epilepsy, seizures
Current Past Headaches, Migraines
Current Past Digestive conditions (Crohn's, IBS)
Current Past Kidney disease, infection

Current Past Arthritis (rheumatoid, osteoarthritis)
Current Past Osteoporosis, degenerative spine/disk
Current Past Scoliosis
Current Past Broken Bones
Current Past Allergies
Current Past Diabetes
Current Past Endocrine/thyroid conditions
Current Past Depression, anxiety
Current Past Disc problem
Current Past Fibromyalgia
Current Past TMJ syndrome
Current Past Bursitis/tendonitis
Current Past Pregnancy
Current Past Nerve damage

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. Understanding all of this, I give my consent to receive care.

Client signature:_____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

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Office Policies

Client Name:_____ Date: _____ Date of Birth:_____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation/ No Show
All cancellations need to be made within 24 hours of the scheduled appointment time. Late cancellations and no shows will be charged $40.

Tardiness
Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Signature _____ Date_____

If this office is providing billing services, please be advised of our billing policies.

Cancellation
We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility
Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility regardless of insurance reimbursement.

Assignment of Benefits
Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records
Your signature below authorizes the release of all of your medical records on file in this office for the purpose of processing your claims to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature _____ Date _____