

## Health Information/Client Intake

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: cell (\_\_\_\_\_) \_\_\_\_\_ home (\_\_\_\_\_) \_\_\_\_\_

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: \_\_\_\_\_



## 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 \_\_\_\_\_