Massage Therapy Intake Form

Personal Information

Name:_____ D.O.B:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell #:_____ Email:_____

Emergency Contact:_____ Cell#:_____

Billing Information:

Referred by:_____ Occupation:_____

Primary Health Care Provider:_____ Phone:_____

Permission to consult with primary provider? Y__ N__

My account will be billed to: Self-Pay Health Ins PIP L&I

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate at any time during my treatment if I feel my well-being is being compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that it is recommended that I see my primary care provider for that service.

ANY REQUIRED PAYMENTS ARE DUE AT TIME OF SERVICE

I hereby authorize and request my insurance company, third-part payers and/or my attorney to pay directly to *(your providers name)*_____ the amount due on my claim for the services rendered to myself or my dependents. I hereby authorize the use of this signature on all insurance submissions.

I clearly understand that I am responsible for payment for services rendered to me or my dependent.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Massage History/Treatment Information

Have you ever received massage therapy before? Y__ N__

What are you looking to achieve with you treatment?_____

Are you currently seeing a medical provider for your issues? If yes, explain:

_____

List stress reduction and exercise activities and frequency.

_____

List current Medications

_____

Health History

Muscles & Joints

Bone or Joint Disease:_____ Broken Bones:_____

Tendonitis/Bursitis:_____ Arthritis:_____

Sprains/Strains:_____ Lower Back Pain:_____

Hip, Leg Pain:_____ Shoulder/Arm Pain:_____

Neck Pain:_____ Spasms/Cramps:_____

Jaw Pain/TMJ:_____ Lupus:_____

Disc Problems:_____ Stiff/Painful Joints:_____

Scoliosis:_____ Weak/Sore Muscles:_____

Other:_____

Circulatory:

Heart Condition:_____ Varicose Veins:_____

Blood Clots:_____ High/Low Blood Pressure:_____

Lymphedema:_____ Stroke:_____

Poor Circulation:_____ Breathing Difficulties:_____

Sinus Problems:_____ Allergies:_____

Other:_____

Skin

Allergies:_____ Rashes:_____

Athletes Foot:_____ Warts:_____

Prone to Bruising:_____

Other:_____

Digestive/Elimination Systems

Constipation:_____ Gas/Bloating:_____

Diverticulitis:_____ Irritable Bowel:_____

Bladder:_____ Kidney:_____

Prostate:_____ Abdominal Pain:_____

Other:_____

Nervous System

Headaches/Head Injuries:_____

Dizziness:_____ Numbness/Tingling:_____

Sharp/Shooting Pain:_____ Chronic Pain:_____

Fatigue:_____ Depression:_____

Sleep Disturbances:_____ Herpes/Shingles:_____

Other:_____

Reproductive

Pregnant? Stage:_____ PMS:_____

Other:_____

Other

Cancer/Tumors:_____ Diabetes:_____

Thyroid:_____ Eating Disorders:_____

Drug/alcohol:_____ Caffeine/Nicotine:_____

Infectious Disease:_____

I attest that all information provided to my provider is correct to the best of my knowledge. I have not withheld any pertinent information out.

Patient Signature:_____ Date:_____