

MASSAGE INTAKE FORM

WELCOME! We would like to make your appointment as comfortable as possible. If at any time you have questions regarding your sessions please let us know.

Date: _____

Name: _____ Sex: M or F (Circle) D.O.B : ____/____/____
(First, Middle Initial & Last Name) Month Date Year

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Health Insurance Company: _____ ID & Group #: _____

Insurance Subscriber Name: _____ Date Of Birth: _____

Who Referred You To Our Office? _____

Reason for Your Visit Today? Auto Accident Work Injury Other: _____

Medical History and Information

Check any or all that apply to your present health:

- | | | |
|--|---|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chronic pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer/tumors |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems or allergies |

Women only: Pregnant Painful Menstruation Endometriosis

Other not listed: _____

List all medications/herbs/vitamins and dosage:

What movements or activities are limited? (What aggravates it?):

List previous major injuries/surgeries:

What other treatments are you receiving and by whom (chiropractic, acupuncture, physical therapy, naturopathic):

PLEASE READ

- If cancellation is necessary, please give 24-hour notice. If you do not give notice you will be charged a \$45 fee at your next appointment. The 2nd time it happens and anytime thereafter, you are charged for the full price of the massage missed. Emergency cancellations are determined at the practitioner's discretion.
- Sessions begin and end at scheduled times. If you arrive late, you will lose that time off your session and will still be charged full price. If the massage therapist starts a session late, she will make it up to you at the end of my session if possible, or will reduce your fee accordingly.
- If you have a cold, flu, sore throat, stomach virus, poison ivy, skin rash, anything contagious please reschedule your appointment.
- Please do not be under the influence of alcohol or drugs because massage can be dangerous to you under these conditions.
- Clients must provide a health history and update when necessary.
- Payment is expected at the time service is rendered.
- Sexual harassment is not tolerated.
- If the practitioner's safety feels compromised, the session is stopped immediately.

Client Signature: _____

Date: _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by **Back To Action** is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have.

I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume those risks.

Client Signature: _____

Date: _____