client intake form

client signature

date of initial visit

personal information

name | date of birth

address

city | state | zip

home phone | cell phone

work phone | ext.

email

occupation

employer

employer address

marital status | if married, spouses name

referred by

emergency contact name (relationship) | emergency contact phone

physician's name | physician's phone

massage experience

Have you had a professional massage before? ◯ Yes ◯ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

health history

Musculoskeletal
- ☐ Bone or joint disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Migraines/Headaches
- ☐ Osteoporosis

Circulatory
- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism

Respiratory
- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ Allergies, specify: _____
- ☐ Sinus Problems

Nervous System
- ☐ Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Chronic Pain
- ☐ Paralysis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease

Reproductive
- ☐ Pregnant, stage _____
- ☐ Ovarian/Menstrual Problems
- ☐ Prostate

Skin
- ☐ Allergies, specify: _____
- ☐ Rashes
- ☐ Cosmetic Surgery
- ☐ Athlete's Foot
- ☐ Herpes/Cold Sores

Digestive
- ☐ Irritable Bowel Syndrome
- ☐ Bladder/Kidney Ailment
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers

Psychological
- ☐ Anxiety/Stress Syndrome
- ☐ Depression

Other
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above :

current health

Reason for initial visit _____

Height & weight _____

Do you exercise regularly and/or participate in any sports? ◯ Y ◯ N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ◯ Y ◯ N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? ◯ Y ◯ N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? ◯ Y ◯ N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? ◯ Y ◯ N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? ◯ Y ◯ N
If yes, describe _____

Do you have sensitive skin? ◯ Y ◯ N

Do you have any allergies to oils, lotions or ointments? ◯ Y ◯ N
If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

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client agreement & health release form

insurance information

client's full name | date

ins. ID # | date of injury

Is your condition the result of an auto accident? ◯ Yes ◯ No

If so, in what state did the accident occur? _____

☐ A work injury? ☐ A health condition? ☐ Other _____

What type of insurance do you have that may cover you for this condition? (*check all that apply*)

☐ Auto ☐ Workers' compensation/state Industrial ☐ Liability ☐ Health

Was a police/accident report filed? ◯ Yes ◯ No

Client's relation to insured? ◯ Self ◯ Spouse ◯ Partner ◯ Child ◯ Other

insured's full name | insured's date of birth

insured's employer | ins. IS #

◯ Male ◯ Female ◯ Single ◯ Married ◯ Partnered ◯ Other

address

city | state | zip

home phone | cell phone

work phone

employer's name/school name

address | phone

primary insurance plan name

group number | plan number

phone

plan's billing address

city | state | zip

secondary insurance information

who is your attending physician? | name

address

city | state | zip

office phone | fax

Permission to consult with _____ regarding _____ Your initials _____

Has an attorney been retained? ◯ Yes ◯ No

name

address

city | state | zip

home phone | work phone

fax

client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the american massage therapy association® has provided this form as a reference and is not held liable for any services provided.

signature | date ◯ ◯

assignment of benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature | date

signature of parent or legal guardian (if client if a minor)

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

signature | date

signature of parent or legal guardian (if client if a minor)

(*Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.*)

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature | date

signature of parent or legal guardian (if client if a minor)

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