Massage Therapy Client Intake Form

Contact Information

Name:_____ Date of Birth:_____/_____/_____

Street Address:_____ City:_____ State:_____

Home Phone:_____ Mobile Phone:_____

Email Address:_____Occupation:_____

Reminder Preference: Email☐ Text Message☐

Secondary Contact Information

Family Doctors Name:_____ Doctors Phone:_____

Emergency Contacts Name:_____ Phone:_____

Insurance Information

Do you have health insurance that covers massage? ☐Yes ☐No ☐ I don't know

Would you like us to verify massage coverage? ☐Yes ☐No

Insurance Provider:_____

Member ID Number:_____ Group Number (if applicable):_____

- Co-pays and coverage are subject to change. It is the clients responsibility to know and understand their insurance coverage policy.
- Disclaimer: Patient is/will be held financially responsible for visits if for any reason the insurance company does not cover costs. Please initial below stating you understand and take responsibility for acquired costs. _____

Health Information

How would you rate your general health? Excellent☐ Good☐ Fair☐ Poor☐

Do you have previous experience with Massage Therapy? _____ When?_____

What is your primary reason for visit?_____

List your Current Medications and the conditions that they are treating:

_____

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Health Information (continued)

List any major any accidents or surgeries (including dates):_____

_____

_____

Please tell us about any allergies or hypersensitivities:_____

_____

_____

How were you referred to us?

☐ Referred By Doctor ☐ Other healthcare practitioner

☐ Internet/ social media ☐ Advertisement

☐ Friend/ family Please specify:_____

Please check if you are having or have ever experienced any of the following symptoms or conditions

Head/ Neck

☐ Headache/ Migraines
☐ Vertigo/ dizziness
☐ Ringing in ears
☐ Hearing loss
☐ Vision Problems
☐ Vision Loss

Musculoskeletal system

☐ Arthritis
☐ Family history of arthritis
☐ Osteoporosis
☐ Tendonitis
☐ Bursitis
☐ Pins/ Plates/ Wires/ artificial joints
☐ Jaw Pain (TMJ)

Skin and Infections

☐ Hepatitis
☐ HIV/AIDS
☐ Tuberculosis
☐ Lyme Disease
☐ Infectious skin conditions
☐ Any other infectious skin conditions

Respiratory System

☐ Asthma
☐ Shortness of breath
☐ Chronic cough
☐ Bronchitis
☐ Emphysema
☐ Sinusitis
☐ Frequent Colds
☐ Smoker
☐ Family history

Other Conditions

☐ Cancer
☐ Diabetes
☐ Unexplained weight loss
☐ Digestive conditions
☐ Fibromyalgia
☐ Chronic Fatigue Syndrome
☐ Depression
☐ Anxiety
☐ Psychiatric Disorder

Reproductive

☐ Pregnant
☐ Given Birth

Nervous System

☐ Sensory loss/ change
☐ Numbness/ tingling
☐ Sciatica
☐ Epilepsy
☐ Seizures
☐ Multiple Sclerosis

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Heart attack
☐ Stroke
☐ Chronic Congestive Heart Failure
☐ Heart Disease
☐ Poor Circulation
☐ Phlebitis/ varicose veins
☐ Pacemaker
☐ Hemophilia
☐ Family history of cardio. Problems

Other Conditions

_____

_____

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Release Form

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnose any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate my massage.

I agree to abide by a 24 hour cancellation notice for any scheduled massage. I understand that I may be charged up to the full amount of service for missed appointments or for any cancellations with less than 24 hour notice. I understand that walk-ins are welcome, but does not guarantee the availability for massage. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. However, if the massage therapist is late, he/she will fulfill the scheduled length of massage or offer a reasonable compensation.

I understand that if I use a coupon during my visit, it is not valid with any other coupons or promotions.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternative techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

_____ Initial verifying you have read Your information, Your rights, Our responsibilities.

Print Name: _____

Signature:_____ Date:_____