# *CLIENT INTAKE FORM*

Captivating massage therapy

## Personal Information

_____
name date of birth

_____
street address

_____
city state zip

_____
cell phone

_____
email

_____
occupation

_____
employer

_____
marital status if married, spouse's name

_____
referred by

_____
emergency contact (relationship, name & phone)

_____
physician's name physician's phone

## Current Health

Have you had a professional massage? ☐ Yes ☐ No

What are the goals for your treatment? _____

_____

Reason for initial visit: _____

_____

Do you participate in any sports? ☐ Yes ☐ No
If yes, what kind? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐ No If yes, please describe:

_____

Do you sit for long hours at a workstation, computer or driving? ☐ Yes ☐ No If yes, please describe: _____

_____

Do you experience stress in your work, family, or other aspects of life? ☐ Yes ☐ No If yes, please describe: _____

Are you experiencing tension, stiffness, discomfort or pain?
☐ Yes ☐ No If yes, please describe: _____

_____

Have you recently had an injury, surgery, or area of inflammation? If yes, please describe: _____

_____

Do you have sensitive skin? ☐ Yes ☐ No

Do you have any allergies to oils, lotions or ointments?
☐ Yes ☐ No If yes, please explain: _____

List any known allergies: _____

List any medications you are currently taking: _____

_____

_____

## Health History

**Musculoskeletal**
__ Bone or Joint Disease
__ Tendonitis/Bursitis
__ Arthritis/Gout
__ Jaw Pain (TMJ)
__ Lupus
__ Spinal Cord Problems
__ Migraines/Headaches
__ Osteoporosis

**Circulatory**
__ Heart Condition
__ Phlebitis/Varicose Veins
__ Blood Clots
__ High/Low Blood Pressure
__ Lymphedema
__ Thrombosis/Embolism

**Skin**
__ Rashes
__ Cosmetic Surgery
__ Athlete's Foot
__ Herpes/Cold Sores

**Psychological**
__ Anxiety/Stress Syndrome
__ Depression

**Other**
__Cancer/Tumors
__ Diabetes
__ Drug/Alcohol/Tobacco Use
__ Contact Lenses
__ Dentures
__ Hearing Aids

**Respiratory**
__ Breathing Difficulty/Asthma
__ Emphysema
__ Sinus Problems

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

**Reproductive**
__ Pregnant, stage: _____
__ Ovarian/Menstrual Problems
__ Prostate Issues

**Digestive**
__ Irritable Bowel Syndrome
__ Bladder/Kidney Ailment
__ Colitis
__ Crohn's Disease

Any other medical Condition(s) not listed:

_____
_____
_____
_____

➔

# *CLIENT INTAKE FORM*

## Primary Insurance Information

_____

client's full name date

_____

inusurance ID# date of injury

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

If so, what state did the accident occur? _____

☐ work injury? ☐ health condition? ☐ other?_____

_____

client's relationship to insured? ☐ self ☐ spouse ☐ child

_____

insured's full name insured's date of birth

_____

insured's employer insurance ID#

☐ Male ☐ Female

_____

address

_____

city state zip

_____

primary insurance plan name

_____

group number plan number

_____

phone

_____

plan's billing address

_____

city state zip

**Secondary Insurance Information**

_____

secondary insurance plan name ID#

_____

address

_____

city state zip

Has an attorney been retained? ☐ Yes ☐ No

_____

Name Phone

### 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. **Initial _____**

### 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 discounted 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. **Initial _____**

Parent or Guardian Signature: _____

### 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 purpose of processing my claims.

_____

Signature Date

_____

Signature of Parent or Legal Guardian (if client is a minor)

### Contract for Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my session' 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.

_____

Signature Date