



INTAKE FORM

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____

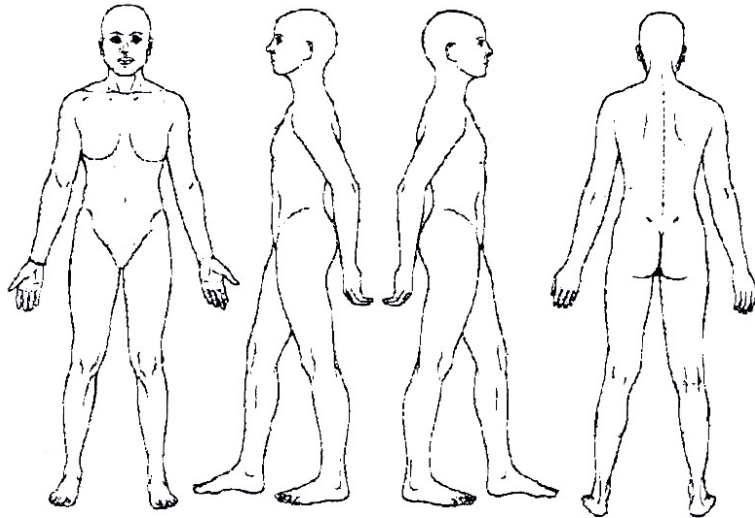
State: _____ Zip: _____

Cell Phone: (_____) _____ Work/Home Phone: (_____) _____

Emergency Contact: _____ Emergency Contact #: (_____) _____

How did you hear about us? _____

CURRENT PAIN:



Where is your current pain?

What are you experiencing? (For example: stabbing, burning, electricity, numbness)

How do you think it started?

Did it start acutely or grow slowly with time?

Do you believe it is related to any other process occurring in your body? (For example: back pain related to you pancreatitis, or developed shoulder pain directly after a hip or low back issue)

MEDICAL HISTORY

Allergies:

Current medications:

Blood thinners: Y or N Blood pressure medications: Y or N

Please list all surgeries with correlating dates (including C-section, Organ removal, implants, stents, rods, fusions, and cosmetic):

Please list all injections with correlating dates (including steroids, stem cells, PRP, and lidocaine):

Please describe your current healthcare team, including PCP, chiropractors, holistic practitioners, specialists, acupuncturists, energy healers, physical therapists, and anyone else you see regularly that keeps you on your path to wellness. (I don't need to know who they are, just what other therapies you are doing and how often).

ACTIVITIES OF DAILY LIFE

Do you exercise? If so, what do you do, and how often?

What are your daily tasks of living? (For example: cooking, cleaning, driving)

What is your profession, and what does it demand of you physically? (Fore example: desk work, regular travel, bicycle tour guide)

INFORMED CONSENT

I, _____ have chosen to consult with and hereby give consent for massage therapy to be provided by the therapist, who I understand is a licensed Massage Therapist.

I have provided a detailed medical history including charts and medications that would affect my therapy, along with any other notable medical factors that would aid in my therapist's knowledge of my medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned, and I understand that massage may provide benefits for certain conditions but results are not guaranteed. **Treatment cannot be performed due to certain conditions (Burns, New surgery, Acute inflammation, open sores or wounds, contagious diseases or viruses) or if the patient is under the influence of substances that would hinder the patient from acknowledging fully the massage being performed.**

Benefits of our session may include manual manipulation of the human body that can fix chronic issues and relieve muscular tension which may also give the patient a better range of motion. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and lightheadedness amongst other possible temporary outcomes. I am aware that the therapist does not diagnose illnesses or prescribe medications, but can recommend an appropriate practitioner to aid the patient in furthering their well being. **I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.**

The privacy of our patients along with their health and well being are of the utmost importance. All information given is securely filed and preserved for the patient and the patient alone unless otherwise noted by the patient. Under no circumstances should any of our clients information will be given to any 3rd party without the express written consent of the client.

If you have read and agree to the above please sign and date below:

Client Signature (or Guardian's):

Date _____

CANCELLATION POLICY:

If an appointment is cancelled within less than 24 hours of said appointment, 50% of the appointment will automatically be charged to the card on file.

If an appointment is cancelled within less than 8 hours of said appointment for any reason, the appointment will be charged at full price.

Client Signature (or Guardian's):

Date _____

EXTERNAL AFFAIRS:

Any tasks or communications performed outside of your appointment time, be it with doctors, lawyers, or insurance companies, will be charged in 15 minutes increments at the same rate as your appointment. Often specific formats for treatments notes need to be compiled for insurance companies, or detailed explanations of treatment need to be written; as this takes the practitioners a great deal of time, it will be compensated as such.

Client Signature (or Guardian's):

Date _____