Massage Intake Form

Signature _____ Date of initial visit _____

Personal information

Legal Name _____ Date of birth _____

Nickname (what you'd like to be called _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Work phone _____ Ext. _____

Email _____ Occupation _____

Employer _____

Employer address _____

☐ Male ☐ Female ☐ Other: _____
☐ Single ☐ Married ☐ Partnered ☐ Other: _____
Spouse/Partner name _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____
Referred by _____

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? _____

Are there any areas, besides those covered by draping at all times, that you would like me to avoid or not to touch?
(Most bathing suit areas will be covered) ☐Yes ☐No
If so, what areas? _____

Current health

Reason for initial visit _____
Height _____ Weight _____
Do you exercise or participate in sports? ☐Yes ☐No
If yes, what activities and how often? _____

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

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

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

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

Have you recently had an injury, surgery, or areas of inflammation? ☐Yes ☐No
If yes, describe _____

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

List any medicines (including herbal) and supplements you take _____

List any known allergies _____

Have you been diagnosed with any conditions? ☐Yes ☐No
If yes, what were you diagnosed with? _____

Treated when and by whom (name and type of healthcare provider) _____

Have you had any major injuries or illnesses? ☐Yes ☐No
If so, please describe _____

BODY TEMPLE WELLNESS

Massage Intake Form

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
_ Fungus or Athletes foot
__ Recent tattoos or piercings

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 conditions not listed:

_____
_____
_____

Please explain any of the conditions that you marked:

_____
_____
_____
_____
_____

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.

_____

signature date

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 is a minor)

Massage Intake Form

Insurance information

Full name _____ date _____

Ins. ID # _____ Date of injury (if any) _____

Is your condition the result of:
☐ An auto accident? 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

Physician Information

Attending physician name _____
Address _____

City _____ State Zip _____

Office phone _____ Fax _____
Permission to consult with your physician regarding _____? ☐Yes ☐No Your initials___.

Attorney Information

Has an attorney been retained? ☐Yes ☐No
Attorney's name _____
Address _____

City _____ State Zip _____

Home phone _____ Work phone _____

Primary insurance

Plan name _____

Group number _____ Plan number phone _____

Plan's billing address _____

City _____ State Zip _____

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

Insured's Full name _____ insured's Date of birth _____

Insured's Employer/School _____ Ins. ID # _____

Employer address _____

Work phone _____

Insured's Address _____

City _____ State Zip _____

Insured's Home phone _____ Cell phone _____

Insured's Work phone _____ Ext. _____

Insured's Email _____ Occupation _____

Secondary insurance information

Plan name _____

Group number _____ Plan number phone _____

Plan's billing address _____

City _____ State Zip _____

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

Insured's Full name _____ insured's Date of birth _____

Insured's Employer/School _____ Ins. ID # _____

Employer address _____

Work phone _____

Insured's Address _____

City _____ State Zip _____

Insured's Home phone _____ Cell phone _____

Insured's Work phone _____ Ext. _____

Insured's Email _____ Occupation _____

BODY TEMPLE WELLNESS

Massage Intake Form

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.)