MASSAGE INTAKE FORM

WELCOME! We would like to make your appointment as comfortable as possible. If at any time you have questions regarding your sessions please let us know.

Date: _____

Name: _____ Sex: M or F (Circle) D.O.B :____/___/____
(First, Middle Initial & Last Name) Month Date Year

Address:_____

City: _____ State: _____ Zip: _____ Phone: _____

Cell Phone: _____ Email: _____

Social Security #: _____ Guardian/Spouse Name & D.O.B : _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Health Insurance Company: _____ ID & Group #: _____

Insurance Subscriber Name: _____ Date Of Birth: _____

Who Referred You To Our Office? _____

Reason for Your Visit Today? __Auto Accident __Work Injury __Other: _____

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___varicose veins
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___ depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems or allergies

Women only: ___Pregnant ___Painful Menstruation ___Endometriosis

Other not listed:_____

List all medications/herbs/vitamins and dosage:

_____

What movements or activities are limited? (What aggravates it?):_____

List previous major injuries/ surgeries:_____

_____

What other treatments are you receiving and by whom (chiropractic, acupuncture, physical therapy, naturopathic):

_____

Is there anyone you want us to send a copy of your treatment progress? Y / N

If Yes, what is your doctors name?:_____ Phone number: _____

PLEASE READ

- If cancellation is necessary, please give 24-hour notice. If you do not give notice you will be charged a $40 fee at your next appointment. The 2nd time it happens and anytime thereafter, you are charged for the full price of the massage missed. Emergency cancellations are determined at the practitioner's discretion.
- Sessions begin and end at scheduled times. If you arrive late, you will lose that time off your session and will still be charged full price. If the massage therapist starts a session late, she will make it up to you at the end of my session if possible, or will reduce your fee accordingly.
- If you have a cold, flu, sore throat, stomach virus, poison ivy, skin rash, anything contagious please reschedule your appointment.
- Please do not be under the influence of alcohol or drugs because massage can be dangerous to you under these conditions.
- Clients must provide a health history and update when necessary.
- Payment is expected at the time service is rendered.
- Sexual harassment is not tolerated.
- If the practitioner's safety feels compromised, the session is stopped immediately.

Client Signature_____ Date_____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by **Back To Action** is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have.

I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume those risks.

Client Signature _____ Date _____