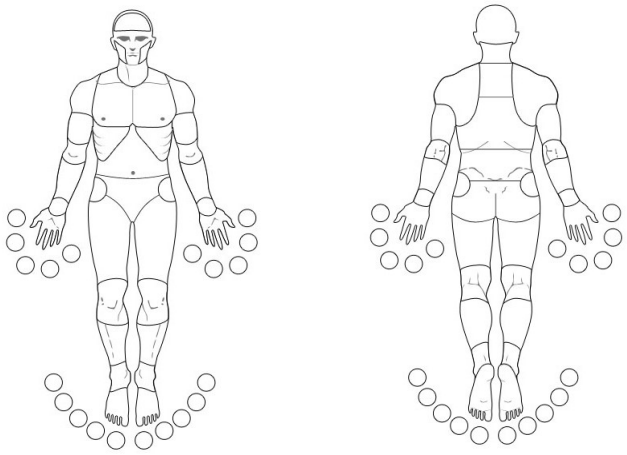
2020

MASSAGE INTAKE

Patient Name_____ Date_____

Complaints/Symptoms

Please mark the areas you are having discomfort in:



1. When did your symptoms appear? _____

2. What treatment have you already received for your condition?
   □ Medication: _____ □ Physical Therapy □ Surgery
   □ Chiropractic Care □ None □ Other: _____

3. Name and Address of doctor(s) or other practitioner(s) who have treated you for this condition:
   _____
   _____

4. Type of Pain:
   □ Sharp □ Dull □ Tingling □ Throbbing
   □ Burning □ Cramps □ Stiffness □ Aching

5. How often do you have this pain?
   □ Constant □ Frequent □ Intermittent □ Infrequent

6. Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

7. Activities or movements that are painful to perform:
   □ Sitting □ Standing □ Walking □ Bending □ Lying Down
   □ Other: _____

HEALTH HISTORY

8. Please check the conditions or symptoms you currently have or have had in the past:

□ Anemia	□ Cancer	□ Hepatitis	□ Multiple Sclerosis	□ Sinus Problems
□ Appendicitis	□ Diabetes	□ Hernia	□ Osteoporosis	□ Stroke
□ Arthritis	□ Emphysema	□ Herpes	□ Pacemaker	□ Tendonitis
□ Asthma	□ Epilepsy	□ High Blood Pressure		□ Tuberculosis
□ Blood Clots	□ Fibromyalgia	□ HIV/AIDS	□ Pneumonia	□ Tumors, Growths
□ Breathing Difficulty		□ Headaches	□ Polio	□ Ulcers
□ Bronchitis	□ Heart Disease	□ Fractures: _____		□ Other: _____

9. Please list the following:

Medications: (Name and Dosage)
Allergies:
Vitamins/Minerals:
Surgeries and Hospitalizations: (Please list date)

10. What describes your exercise regime: □ Heavy □ Moderate □ Light □ None

11. Lifestyle:
□ Smoking Packs/Day_____
□ Alcohol Drinks/Day_____
□ Caffeine/Coffee Cups/Day_____
□ High Stress Level

12. Are you pregnant? □ Yes □ No (If Yes) Due Date:_____

13. Employment: □ Full Time □ Part Time □ Retired □ Student □ Unemployed
Employer:_____

14. What best describes your physical stress level at work?
□ None □ Mild □ Mild to Moderate □ Moderate □ Moderate to Extreme □ Extreme

15. What is your primary work position and location?
a. Work position: □ Seated □ Standing □ Other _____
b. Work location: □ Desk □ Counter □ Workbench □ Other _____

16. Do work activities aggravate your present complaints? □ Yes □ No
If yes, explain:
_____

Massage History

Have you ever received a professional massage? □ Yes □ No
Why did you come in for our service? □ Relaxation □ Pain □ Therapy □ Other
What results would you like to achieve?

_____

_____

Please note any areas of your body that you prefer not to be massaged: _____

_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. I understand that it is my responsibility to inform my health care provider if ever I have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

I hereby authorize the release of any medical information necessary to process this claim and or medical provider necessary for my health and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be applied to my account upon receipt. However, I clearly understand and agree that all services rendered to me I am personally responsible for payment.

Patient Name _____ Signature _____ Date _____

Parent or Guardian if minor _____ Signature _____ Date _____

Massage Policies

PLEASE READ AND INITIAL BY EACH PARAGRAPH

1._____ All massage appointments are reserved especially for you, so we require that any cancellations or rescheduling be done with at least 24 hours' notice. If our office is closed, please leave a message so we can assist you as soon as we return, please do not respond via text message to cancel your massage. If your appointment is Monday morning please call our office Friday to cancel or reschedule any appointments. **If an appointment is missed (no show, no call) or cancelled without 24 hours' notice, you will be charged a missed/ cancellation fee outlined below**. This fee is due upon notice and further massages will not be scheduled until the fee is paid. If you are already scheduled for future appointments, your fee must be paid before your next massage or it will result in canceling your future appointment. Please note that this is to protect our massage therapist's livelihood and not just to be rigid. We appreciate your respect of our team's time and commitment to providing you with exceptional service. *Insurance companies/ Third Party payers do not pay for fees for missed services.*

2._____ Please plan to arrive 10 minutes prior to your massage as your arrival time will determine the length of treatment which will end as originally scheduled. If you will be late to your scheduled appointment, please call with your estimated arrival time so we can determine whether we can accommodate your massage. If you are over 20 minutes late you will be asked to reschedule your appointment and will be charged a cancellation fee.

3._____ We are glad to work with you and your insurance company to provide personalized care. In doing so, we ask that you do not switch or transfer your appointment to a friend or family member. If you are unable to make your appointment, please call to cancel and have that person call in to schedule. Our therapist has a waitlist of patients who need care and we would like to make sure everyone can be on the path to recovery and healing.

4._____ If we are billing insurance, a prescription (referral) is needed from your provider. In order for our office to follow your treatment plan and recommendations set by your provider, we are currently booking massage appointments no further than three months at a time. If we do not have your prescription on file at the time of your massage, we will ask you to pay for the service in full.

5._____ If you would like a massage that does not meet the guidelines of your referral, you will directly be responsible for payment. Your insurance will not pay for services that are not deemed medically necessary.

Missed Massage Fees

30 Minute Massage……..$50.00
60 Minute Massage……..$75.00
90 Minute Massage……$120.00

Patient Name _____ Signature _____ Date _____

Parent or Guardian if minor _____ Signature _____ Date _____