

client intake form

client signature _____

personal information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____ ext. _____

email _____

occupation _____

employer _____

employer address _____

marital status _____ if married, spouses name _____

referred by _____

emergency contact name (relationship) _____ emergency contact phone _____

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? _____

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

date of initial visit _____

current health

Reason for initial visit _____

Height & weight _____

Do you exercise regularly and/or participate in any sports? Y N

If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? Y N

If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? Y N

If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Y N

If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N

If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Y N

If yes, describe _____

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions or ointments? Y N

If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

Skin

Allergies, specify: _____

- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

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 condition(s) not listed: _____

Please explain any of the conditions that you have marked above :

client agreement & health release form

insurance information

client's full name _____ date _____

ins. ID # _____ date of injury _____

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

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

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

insured's full name _____ insured's date of birth _____

insured's employer _____ ins. IS # _____

Male Female Single Married Partnered Other

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____

employer's name/school name _____

address _____ phone _____

primary insurance plan name _____

group number _____ plan number _____

phone _____

plan's billing address _____

city _____ state _____ zip _____

secondary insurance information

who is your attending physician? _____ name _____

address _____

city _____ state _____ zip _____

office phone _____ fax _____

Permission to consult with _____ regarding _____ Your initials _____

Has an attorney been retained? Yes No

name _____

address _____

city _____ state _____ zip _____

home phone _____ work phone _____

fax _____

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. I understand that the American Massage Therapy Association® has provided this form as a reference and is not held liable for any services provided.

signature _____ date _____

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.)

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 if a minor)

This form was created as a resource by the American Massage Therapy Association® and they are not held liable for any services provided.