Client Intake Form – Medical Massage

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

E-mail:_____ Social Security #:_____

Emergency contact:_____Relationship:_____ Phone: ( )_____

Referred by: _____

General & Health Information

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Have you ever had a professional massage?

☐ Yes ☐ No Do you experience frequent headaches?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Are you diabetic?

☐ Yes ☐ No Do you have high blood pressure?

☐ Yes ☐ No If you have high blood pressure, are you taking medication for this?

☐ Yes ☐ No Are you currently being treated for cancer?

☐ Yes ☐ No Do you have any other medical conditions your massage therapist should be aware of?

☐ Yes ☐ No Have you had any broken bones in the past 2 year

☐ Yes ☐ No Do you have tension or soreness in a specific area?

☐ Yes ☐ No Do you have cardiac or circulatory problems?

☐ Yes ☐ No Do you suffer from back pain?

☐ Yes ☐ No Are you very sensitive to touch/pressure in any ar

☐ Yes ☐ No If female, are you pregnant?

☐ Yes ☐ No Do you suffer from seizure disorders or epilepsy?

☐ Yes ☐ No Have you ever had surgery? If yes, please explain in the comments areas of this form.

Comments:

_____

_____

Appointment Reminder Would you like to receive an appointment reminder? ☐ Yes ☐ No
If yes, how? ○ E-mail Phone: ○ Home ○ Work ○ Cell ○ Text

Payment Method How will you be paying for this visit? ☐ Cash ☐ Check ☐ Credit Card (MC/Visa/Disc) ☐ Insurance
Payment is due at the time of service, unless otherwise arranged. There is a $35 Returned Check Fee.

I hereby authorize the release of medical information necessary to comply with regulations. This may include intake forms, chart notes, reports, correspondence, billing statements, and any other information to attorneys, health care providers and others as provided by law.

Signature:_____ Date:_____ / _____ / _____

Financial Agreement

I_____ acknowledge that I am responsible for full payment of my account. In Touch Therapy will attempt to secure payment from my insurer. If my insurer issues partial payment or denies my claim, I will pay the balance of my account to In Touch Therapy. If I do not call 24 hours before my scheduled appointment to cancel, I am responsible for paying In Touch Therapy for the missed appointment and this missed appointment will not be billed to my insurance.

Signature:_____ Date:_____ / _____ / _____