

# client intake form

client signature \_\_\_\_\_

## personal information

name \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

home phone \_\_\_\_\_ cell phone \_\_\_\_\_

work phone \_\_\_\_\_

email \_\_\_\_\_

occupation \_\_\_\_\_

marital status \_\_\_\_\_

referred by \_\_\_\_\_

emergency contact name \_\_\_\_\_ 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

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 : \_\_\_\_\_

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

# 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 \_\_\_\_\_

ins. IS # \_\_\_\_\_

date of birth \_\_\_\_\_

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 or 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) \_\_\_\_\_

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