Massage Therapy Intake Form

Name______________________________ Date______________

Address____________________ City,St,Zip____________________

Home ______________ Cell______________ Work______________

Date of Birth______________ SS#______________________

Occupation__________________ Email______________________

Massage Information

How did you hear about us? ____________________

Have you ever had a professional massage before? ☐yes ☐no

If yes, how often to you receive massage therapy? __________

If yes, do you have a style or pressure preference? ☐yes ☐no

Specify : ☐ light pressure ☐ medium pressure ☐ deep pressure

☐ trigger point therapy ☐ energywork

☐ Other ______________

What Type of massage are you seeking today?

☐ Relaxation ☐ Deep Tissue/Therapeutic ☐ Pregnancy

☐ Senior ☐ Integrated Bodywork (*functional*)

☐ Other ______________

Are you sensitive to fragrances or perfumes? ☐ yes ☐ no

Do you have sensitive skin? ☐ yes ☐ no

Do you wear contact lenses? ☐ yes ☐ no

Do you exercise regularly? ☐ yes ☐ no

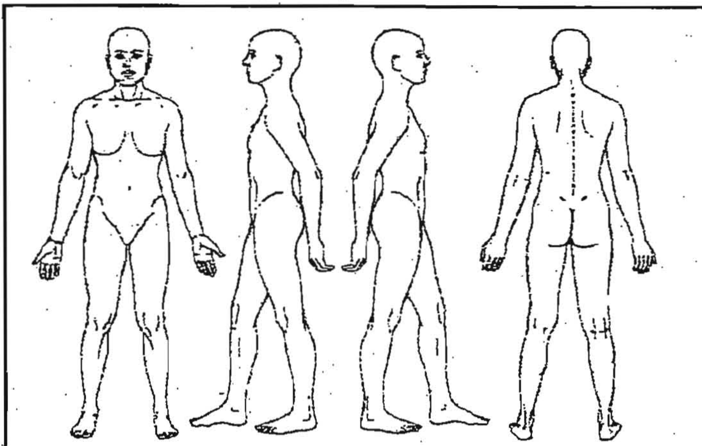
If so, what type(s)? ____________________

What are your common areas of pain or tension?

____

____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you suffer from chronic or persistent pain/discomfort?

____

If so, for how long? ____________________

Do you know what caused it or when the symptoms seem to get worse or better? ______________

____

Do you see a chiropractor? ☐ yes ☐ no

If so, how often? ____________________

Are you currently under medical care? ☐ yes ☐ no

Are you currently taking any prescription medication? If so, for what? ______________

____

____

Please indicate any conditions that you have had or currently have:

☐ headaches, migraines	☐ varicose veins
☐ allergies, sensitivity	☐ pregnancy
☐ arthritis, tendonitis	☐ blood clots
☐ cancer, tumors	☐ neck / back injuries
☐ TMJ problems	☐ diabetes
☐ abnormal skin condition	☐ paralysis
☐ heart/circulation problems	☐ fibromyalgia
☐ joint replacement / surgery	☐ numbness
☐ high / low blood pressure	☐ sprains, strains
☐ major accident	☐ recent injuries

☐ lack of or reduced feeling / sensation __________

Explain any conditions that you have marked above:

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	INFORMED CONSENT TO MASSAGE THERAPY

TERMS OF ACCEPTANCE FOR CARE

When a patient seeks massage therapy and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommend care and treatment to be provided so that you may make the decision whether or not to undergo massage therapy after being advised of the known benefits, risks, and alternatives. Please be aware the clinic is under video and audio surveillance for training and security purposes, however no surveillance equipment is present in the massage treatment rooms.

We require that you notify your therapists of all known physical conditions and medical conditions. Certain conditions could hinder or affect your treatment. Please do not take any prescription pain medication or over the counter pain relievers prior to your session. Please do not drink alcohol or excessive amounts of caffeine prior to your massage. Side effects of massage therapy may include temporary pain or discomfort, bruising, swelling, and a sensitivity or allergy to massage oils.

Types of Massage Therapy:
In **Swedish massage**, the therapist uses long strokes, kneading, deep circular movements, vibration, and tapping. **Sports massage** is similar to Swedish massage, adapted specifically to the needs of athletes. Among the many other examples are **deep tissue massage; trigger point massage** , which focuses on myofascial trigger points—muscle "knots" that are painful when pressed and can cause symptoms elsewhere in the body; and **reflexology** , which applies pressure to the feet (or sometimes the hands or ears), to promote relaxation or healing in other parts of the body. In massage sessions, draping will be used-only the area being worked on will be uncovered. Undress to your level of comfort.

Each massage session is 60 minutes of time. Therefore, if you are late for your appointment, your massage therapist can only treat you for the remainder of the time. If we are behind schedule, you will receive your full massage session.

Due to limited appointment availability, we require **24 hour notice** for cancellation of massage appointments. If less than 24 hour notice is given, a **$40.00 cancellation fee** will be charged to you, the patient. Your insurance company will not pay for cancellation/no show fees.

Informed written consent must be provided by a parent or legal guardian for any patient under the age of 17.

CONSENT TO TREAT A MINOR CHILD.

I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

All questions regarding treatment in this office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept massage therapy on this basis.

______________________________ ______________________________

Print Name **Signature** **Date**

FINANCIAL PAYMENT POLICY

INSURANCE

Insurance coverage is never guaranteed. Any benefits quoted by our staff are not a guarantee of benefits. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to use and disclose protected health information for purposes of treatment, payment, and healthcare operations. You have a right to review our posted privacy policy before you sign this consent and you may void your consent at anytime by contacting us.

FINANCIAL POLICY

The office manager may approve account balances. Active monthly payments are required. Monthly payments are due on the 10th of each month. If account becomes 60 days past due, agreement is null and void and payment must be made at the time of service. Past due accounts may be sent to a third party collection agency.

We do offer a *time of service* discount when services are paid in full at time of the visit. This discounted amount will be passed on to your insurance company contract permitting. Please feel free to ask us any financial question you may have. Our intent is to provide you with the highest level of service as well as care.

All questions regarding financial matters have been answered to my complete satisfaction. I have read and fully understand the above financial payment policy.

______________________________ Signature

______________________________ Date

CONSENT to **LEAVING MESSAGES**
CONSENT to **SHARING INFORMATION** with **Family/ Friends**

CONSENT to LEAVING MESSAGES

I understand that my healthcare information at Lifeplus Health Centers, P.S. is protected and I have received a copy of its Notice of Privacy Practices.

I further understand that, in order for Lifeplus Health Centers to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Lifeplus Health Centers.

Consent for Leaving Messages
I consent to information regarding my or my child's (under the age of 18) detailed appointment reminders, insurance benefit information, and/ or instructions be left on my voice mail or answering machine.
[ ] YES [ ] NO

CONSENT for SHARED INFORMATION with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my health care providers and their representatives at Lifeplus Health Centers to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment. **[ ] YES [ ] NO**

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of information form.

NAME	RELATIONSHIP
1.____________________	____________________
2.____________________	____________________
3.____________________	____________________

________________________ ____________________
Patient/ Parent Signature Date

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to my provider at Lifeplus Health Centers.