NATURAL PAIN MANAGEMENT AND WELLNESS

Massage Therapy Intake Form

Personal Information

Name: _____ Phone (Day): _____ Phone (Evening): _____

Address (City, State Zip Code): _____

Email: _____ Occupation: _____ Birth Date: _____

Sex: □ Male □ Female □ Other Status: □ Married □ Widowed □ Single □ Divorced □ Separated □ Partner □ Minor

In Case of Emergency Contact: Name: _____ Phone Number: _____

Would to receive reminders by □ text □ email □ phone call

Insurance Information

Regular Insurance:

Carrier: _____ Subscribers Name: _____

Group Number: _____ Identification Number: _____

Subscribers Relationship to Patient: _____ Social Security Number: _____

Only Workers Compensation/ No Fault Patients Complete:

WCB/NF Case Number: _____ Date of Injury: _____

Carrier _____ Carrier Case Number: _____

Carrier Address _____

Adjusters Name: _____ Adjusters Phone Number: _____

Adjusters Fax Number: _____

Employers Name and Address at Time of Injury: _____

_____

Massage Information

How did you hear about us? _____ Have you ever had a professional massage before? □ Yes □ No

If yes, how often have you received massage therapy? _____

If yes, do you have a style or pressure preference? □ Yes □ No

Specify: □ Light Pressure □ Medium Pressure □ Deep Pressure □ Trigger Point Therapy □ Energy Work (You can check more than one)

Do you have sensitive skin? □ Yes □ No Are you sensitive to fragrances or perfumes? □ Yes □ No

What is your current stress level? □ No Stress □ Low Stress □ Medium Stress □ High Stress

Are you Pregnant? □ Yes □ No If yes, how many weeks? _____ Any complications with the pregnancy? _____

Do you exercise? □ Yes □ No If yes, how often? _____ Do you bruise easily? □ Yes □ No

Is there anything you would like your therapist to know? _____

_____

Client Condition

Give a brief description of the problem/ problems you are having_____

_____

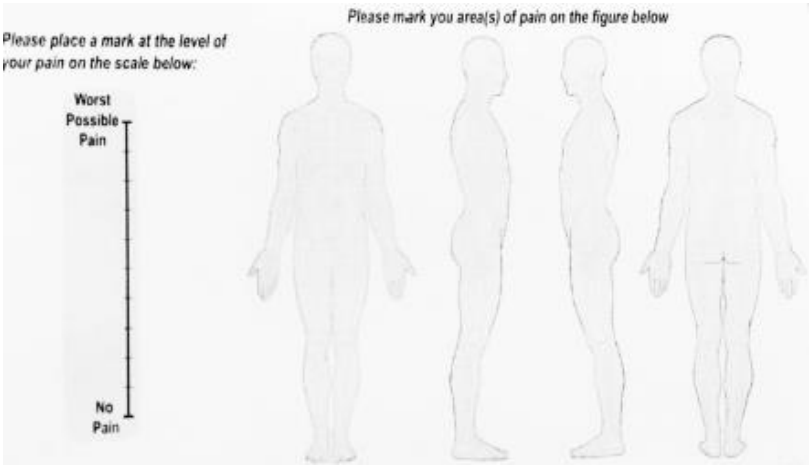
Have you had a similar problem in the past? When? How did you treat it? _____

_____

Please describe the pain you feel (i.e. burning, aching, stabbing, etc.) _____

How often do you experience the pain? _____ When did this condition begin? _____

Is the pain getting □ Better □ Worse □ Same What seemed to be the initial cause? _____



Medical History

Are you currently taking and prescription medications? If so, for what?

_____

Do you take vitamins/ herbs/ minerals? If yes, which ones:_____

Do you have any allergies? If yes, explain _____

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

□ headaches, migraines
□ pregnancy
□ cancer, tumors
□ diabetes
□ heart/ circulation problems
□ numbness
□ major accident_____
□ broken bones_____
□ varicose veins
□ arthritis, tendonitis
□ neck/back injuries
□ abnormal skin conditions
□ fibromyalgia
□ high/ low blood pressure
□ recent injuries_____
□ allergies, sensitivity
□ blood clots
□ TMJ problems
□ paralysis
□ joint replacement/ surgery
□ sprains, strains_____
□ reduced feeling/ sensation
□ rash/ hives

Surgical History

	Date	Procedure	Description	Imaging	In or Out Patient?
1					
2					
3					
4					
5					

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. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider of I ever 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 substitution for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any 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 its nature and it to be used at my own discretion.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient