

# MESSAGE CLIENT INTAKE FORM

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Work phone, ext.: \_\_\_\_\_  
Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer address: \_\_\_\_\_  
Marital status: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Emergency contact name (relationship): \_\_\_\_\_  
Emergency contact phone: \_\_\_\_\_  
Physician's name and phone: \_\_\_\_\_

## MASSAGE PREFERENCES

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?: \_\_\_\_\_  
Any areas you'd not want to be massaged?: \_\_\_\_\_

## CURRENT HEALTH

Reason for initial visit: \_\_\_\_\_  
Do you exercise regularly and/or participate in any sports?  Yes  No  
If yes, what kind?: \_\_\_\_\_  
Do you perform any repetitive movement in your work, sports or hobby?  
 Yes  No  
If yes, describe: \_\_\_\_\_  
Do you sit for long hours at a workstation, computer, or driving?  Yes  No  
If yes, describe: \_\_\_\_\_  
Do you experience stress at work or in your personal life?  
 Yes  No  
If yes, describe: \_\_\_\_\_  
Are you experiencing tension, stiffness, discomfort or pain?  Yes  No  
If yes, describe: \_\_\_\_\_  
Have you recently had an injury, surgery, or areas of inflammation  Yes  No  
If yes, describe: \_\_\_\_\_  
Do you have sensitive skin?  Yes  No  
Do you have any allergies to oils, lotions or fragrances?  Yes  No  
If yes, explain: \_\_\_\_\_  
List any medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
List any known allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CLIENT SIGNATURE: \_\_\_\_\_

## DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

### CHECK ALL THAT APPLY

#### MUSCULOSKELETAL

- Bone or joint disease
- Arthritis/Gout
- Lupus
- Migraines/Headaches
- Tendonitis/Bursitis
- Jaw Pain (TMJ)
- Spinal Problems
- Osteoporosis

#### CIRCULATORY

- Heart Condition
- Blood Clots
- Lymphedema
- Phlebitis/Varicose Veins
- High/Low Blood Pressure
- Thrombosis/Embolism

#### RESPIRATORY

- Breathing Difficulty/Asthma
- Allergies, specify: \_\_\_\_\_
- Emphysema
- Sinus Problems

#### NERVOUS SYSTEM

- Shingles
- Pinched Nerve
- Paralysis
- Parkinson's Disease
- Numbness/Tingling
- Chronic Pain
- Multiple Sclerosis

#### REPRODUCTIVE

- Pregnant, week \_\_\_\_\_
- Ovarian/Menstrual Problems
- Prostate issues

#### SKIN

- Allergies, specify: \_\_\_\_\_
- Cosmetic Surgery
- Herpes/Cold Sores
- Rashes
- Athlete's Foot

#### DIGESTIVE

- Irritable Bowel Syndrome
- Colitis
- Ulcers
- Bladder/Kidney Ailment
- Crohn's Disease

#### HEAD/NECK

- Headaches/Migraines
- Ringing in Ears
- Vision Problems
- Vertigo/Dizziness
- Hearing Loss
- Vision Loss

#### PSYCHOLOGICAL

- Anxiety/Stress/PTSD
- Depression

#### OTHER

- Cancer/Tumors
- Drug/Alcohol/Tobacco Use
- Dentures
- Any other medical condition(s) not listed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Diabetes
- Contact Lenses
- Hearing Aids

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

CLIENT SIGNATURE: \_\_\_\_\_

# INSURANCE INFORMATION

## INSURANCE INFORMATION

Client's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Insurance. 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?: \_\_\_\_\_

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 Massage Magazine Insurance Plus 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/legal guardian (if client is 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, health care providers, and insurance case managers, for the purposes of processing my claims.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of parent/legal guardian (if client is a minor):

\_\_\_\_\_

## COVID-19 AGREEMENT

I knowingly and willingly consent to have massage therapy during the COVID-19 pandemic. I understand that the COVID-19 virus can have a long incubation period, during which carriers of the virus may not show symptoms and can still be highly contagious. I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever temperature over 99.6°F degrees
- Chills with or without body aches
- Shortness of breath
- New loss of sense of taste or smell
- Unexplained sores on soles of feet
- Unusual fatigue
- Cough
- Sore throat

Please seek immediate medical attention if you are displaying any severe signs of COVID-19.

I confirm that I have not been in close contact with anyone exhibiting the above COVID-19 symptoms within the past 14 days. I further confirm that I am not currently living with anyone who is sick or who is quarantined. To prevent the spread of contagious viruses and to help protect each other, I understand that I will have to follow the massage therapist's guidelines.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)

*This form was created by Massage Magazine Insurance Plus. They are not held liable for any services provided.*