MASSAGE 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
❑ Diabetes
❑ Contact Lenses
❑ Hearing Aids
❑ Any other medical condition(s) not listed:

_____
_____
_____
_____

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

_____
_____
_____
_____

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.)

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