Date ____/____/_____

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐yes ☐no

If yes, please list name and use: _____

_____

_____

Are you currently pregnant? ☐yes ☐no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐yes ☐no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐yes ☐no

If yes, please list: _____

_____

Please indicate any condition you have had in the past or currently have.

☐Cancer	☐Fibromyalgia
☐Headaches/Migraines	☐Stroke
☐Arthritis	☐Heart Attack
☐Diabetes	☐Kidney Dysfunction
☐Joint Replacement(s)	☐Blood Clots
☐High/Low Blood Pressure	☐Numbness
☐Neuropathy	☐Sprains or Strains

Explain any conditions you have marked above:

_____

_____

Massage Information

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

What type of massage are you seeking?

☐Relaxation ☐Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐Light ☐Medium ☐Deep

Are you sensitive to any fragrances? ☐yes ☐no

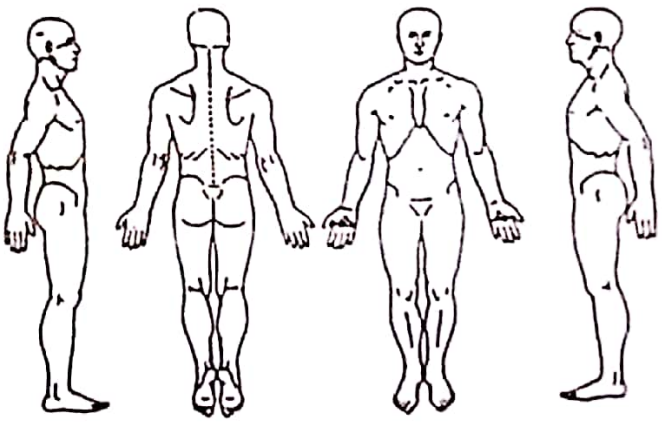
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Practitioner/Clinic Name: _____

Contact Information: _____

Office Policies

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

If this office is providing billing services, please be advised of our billing policies.

Cancellation

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____