Massage Intake Form

GENERAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Work Phone _____ Occupation _____

Email _____

Emergency Contact _____ Contact Number _____

Family Physician _____ Physician Phone _____

Referred By _____

Are you presently under a doctor's care? ____ Yes ____ No

Who and for what? _____

Are there any other therapies, which you are involved in? ____ Yes ____ No

Who and for what? _____

Massage History

Have you had massage or Bodywork before? ____ Yes ____ No

If Yes, Frequency: _____

Types of Massage or Bodywork Received? _____

Preferred types of massage: _____

Reasons for seeking massage (relaxation, injury, etc.): _____

How did you hear about us? (Referral, Facebook, etc.) _____

FOCUS

What is your primary reason for seeking massage at our clinic (relaxation, injury, etc.? _____

_____

_____

What was the initial cause? _____

When did it begin? _____

What makes it better? _____

What makes it worse? _____

How does the problem interfere with your daily activities?

___ Work ___ Sleep ___ Walking ___ Sitting ___ Standing ___ Bending

___ Stretching ___ Emotional ___ Relationships ___ Social Life ___ Sexually ___ Recreation

___ Other (list to the right) _____

What have you done about this? _____

_____

Are you interested in?

___ Pain Relief ___ Performance Care ___ Maintenance Care

___ Preventative Care ___ Holistic Health ___ Stress Relief

___ Oriental Nutrition ___ Meridian Yoga ___ Herbal Therapy

Expected outcomes (functional improvement, symptom relief, wellness): _____

_____

_____

Best times for massage (days of the week, time of day): _____

Medications, Supplements, & Allergies

Do you have any allergies? ___ Yes ___ No If so, to what? _____

_____

Do you have any known allergies or sensitivities to topicals such as lotions or oils?

___ Yes ___ No If so, what? _____

Do you take medication? ___ Yes ___ No If so, what types and how often? _____

_____

Do you take supplements? ___ Yes ___ No If so, what types and how often? _____

_____

PAIN

Pain intensity levels (please indicate below which best describes)

___No pain ___Moderate pain ___Severe pain ___Terrible pain

Sleeping

___No problem ___Mildly disturbed ___Greatly disturbed ___Cannot sleep

Work – Can do:

___Usual work ___25% of work ___50% of work ___No work

Frequency of pain

___25% of time ___50% of time ___75% of time ___100% of time

Travel

___No problem on long trips ___Moderate pain on trips ___Severe pain on trips

Recreation – Can do:

___All activities ___Some activities ___No activities

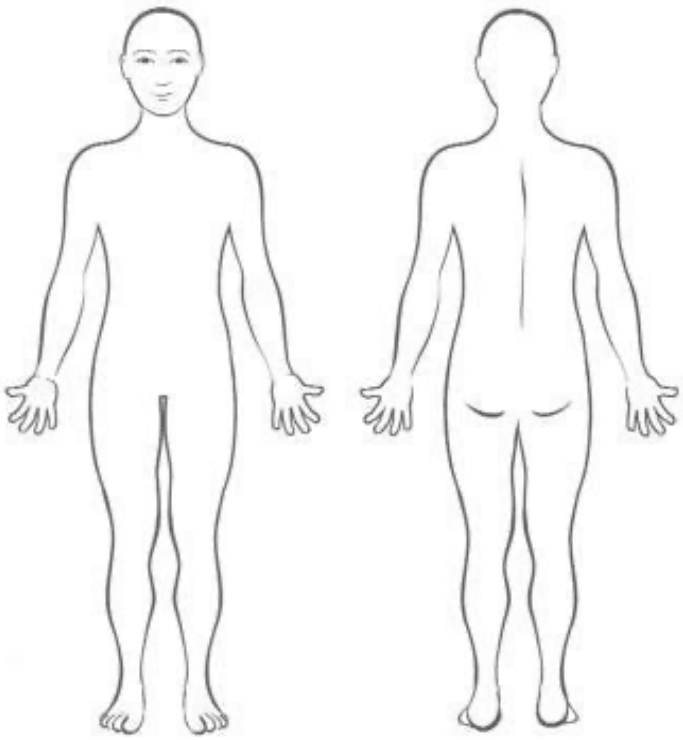
Walking

___Can walk any distance ___Pain after 1/2 mile ___Cannot walk

Sitting

___No pain sitting ___Some pain while sitting ___Cannot sit

Please indicate areas of pain/tension/tightness/discomfort on the chart below.



Other Considerations

Do you have special needs I should prepare for?

_____

_____

Do you have any questions or concerns?

_____

_____

Additional Notes:

_____

_____

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 agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

Signature _____ Date_____

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

_____ Date_____

Massage Therapist Signature_____ Date_____

Cancellation Policy and Treatment Program Agreement

At least a 24-hour notice of cancellation of any appointment is requested by Modern Point. I understand that if I arrive late for a scheduled massage appointment this will reduce the therapeutic portion of my massage appointment. If I do not give 24-hours' notice of a missed appointment I will be charged for the entire amount of the missed appointment. If a pre-paid program applies, the amount of the entire appointment will be deducted from my prepaid massage program. _____Initial

The 24-hour cancellation fee is not a penalty. Modern Point Clinic provides an exclusive reservation to me and in exchange I accept the costs associated with cancellation on less than 24-hours' notice. Modern Point Clinic does not want to be in the position of having to evaluate good/bad reasons for cancellations.
_____ Initial

Treatment Programs: I consent Modern Point to take payment for and to track the number of visits used for my prepaid massage treatment program. I understand that massage treatment programs are non-transferable, non-refundable*, and expire one year from the date of purchase. This policy is designed for the benefit of both patients and practitioners so that appointments are available to those in need of treatment. _____ Initial

I have read, and I understand the above information:

_____
Client name printed

_____ _____
Client Signature Date

_____ _____
Office signature Date

*In the rare circumstance that a refund is given for a partially used treatment program the regular treatment price (not the discounted program treatment price) is deducted from the total amount paid for the program for each treatment used.

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:
Limited access to facilities where information is stored.

Policies and procedures for handling information.

Requirements for third parties to contractually comply with privacy laws.

All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:

About your financial transactions with us (billing transactions).

From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

From health care providers, insurance companies, workers comp and your employer, and other third-party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you – e.g. your name, address, Social Security Number, etc.).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 763-494-9500.

I have read and understand this privacy policy.

X: _____ Date: _____

Patient Signature