Massage Therapy Intake Form - CONFIDENTIAL

All information is strictly confidential and is intended to help you.

General Information	Date:	
Name:	Sex:	Age:
Address:	Height:	Weight:
	Email:	
Home Phone: Work Phone.	Cell:	
Emergency Contact Name:	Contact Phone:	
Doctor's Name:	Doctor's Phone:	

How did you hear of us?	Stress Level: High Medium Low
For a referral: do we have your permission to thank this person for referring you? Yes No	Occupation:
Level of Activity: None Minimum Some Regular Athlete	Have you ever received massage Therapy? Yes No
Have you ever been injured? Car Job Accident Sports	If yes, what pressure do you prefer? Light Medium Deep
How long ago was the injury?	How long ago was your last massage?
Area of Injury?	Any part of your body that you do NOT want massaged?

Do you have any of the following today?

____ Cold / Flu ____ Skin Rash
____ Open Cuts ____ Severe Pain
____ Injuries / bruises ____ Anything Contagious

What are you looking to get from massage? Circle all that apply

Stress Reduction Injury Rehabilitation
Pain Management Relaxation

Medical History: Check all that apply. Indicate P for Past, C for Current

____ If Female: Pregnant? Trimester____	____ Claustrophobic	____ Right or Left handed
____ Chronic Headaches / Migraines	____ Carpal Tunnel Syndrome	____ Arthritis
____ Allergies (hay fever, pollen, etc...)	____ TMJ	____ Numbness / tingling
____ Chronic Pain: _____	____ Scoliosis	____ Varicose veins / blood clots
____ Nausea, Fainting, Dizziness, Vertigo	____ Digestive issues	____ Inflammation / swelling
____ Whiplash	____ High cholesterol	____ Muscle cramping, Strain or Pull
____ Asthma / Breathing Difficulty	____ Low / High blood pressure	____ Fibromyalgia / Chronic Fatigue
____ Diabetes	____ Chemical Dependency	____ Lyme disease / AIDS / Hepatitis
____ Skin trouble / skin allergies	____ Heart Conditions	____ Contagious Disease *please explain
____ Contacts / dentures	____ Bruise easily	Explain: _____
____ Epilepsy or Seizures	____ Osteoporosis	____ Cancer – type: _____

Other (please specify): _____

_____

Allergies: Please list foods, drugs, oils, nuts, lotions, essential oils, or other known allergens: _____

_____

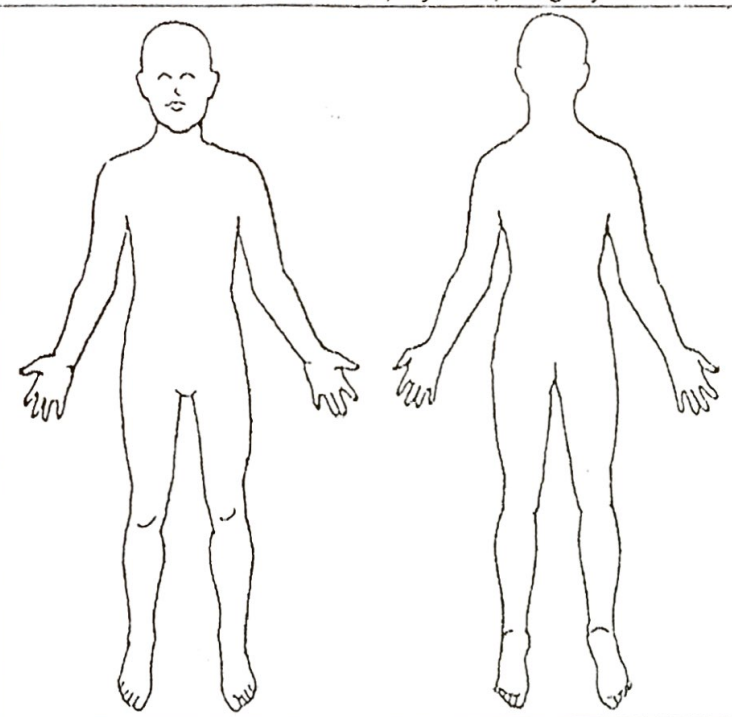
Please list any prior surgeries: _____ When _____

When When

Medications & Supplements

Name of Prescription	*For what health issue?*	*When was the last time you took this?*

"O" (circle) locations that are in particular discomfort
"X" locations of broken bones, injuries, surgery



Please notify us at anytime if:

- Room temperature is too cold or warm.
- If you feel faint or ill.
- The music is not to your liking, or too loud or soft.
- The massage touch is too deep or not deep enough.
- You would like me to stop the massage
- You would like additional massage in a particular area that needs attention.
- If any technique is or is not to your liking.

The following are normal responses to relaxation that may sometimes occur during massage. Trust your body.

- You need to move or change position.
- Sighing, yawning, change in breathing
- Stomach gurgling (or release of internal gas)
- Emotional feelings and/or expression.
- Falling asleep
- Memories of past accidents or trauma

Rules and Policies to help make your Massage more pleasurable:

- Please notify this office 24 hours in advance of any cancellation of your appointment.
- Promptly notify us of any injuries or changes in your health issues when making your appointment.
- Any client under the age of 18 must be accompanied by a parent or legal guardian.
- All notes, questionnaires, conversations, and client information will be kept strictly confidential.
- We encourage you to shower or wash for hygienic reasons prior to your massage.
- Your privacy will be respected at all times with proper draping. Please help us maintain propriety during your massage.
- Please refrain from wearing perfumes or jewelry when coming for a massage.
- Please turn off all electronic devices inside the office or treatment room.
- Payment is due at the time of the massage unless other arrangements have been made in advance.

I understand that massage therapy is for the purpose of stress reduction, relief from muscular discomfort and for increasing blood, lymph and energy circulation. I further understand the massage therapist does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe medical treatment, medication(s) and does not perform spinal manipulation. By signing below, I further agree that I will not hold the massage therapist or its affiliates responsible should there be any unfavorable outcome or result. I have filled out this questionnaire and stated all my known medical conditions. I will keep the massage therapist updated on my physical health.

I am receiving a therapeutic massage. Any inappropriate sexual behavior will terminate the session and I will be liable for payment of the scheduled treatment.

Client Signature: _____ *Date:* _____

Consent to Treatment of Minor: by my signature below, I hereby authorize the massage therapist to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ *Date:* _____

Intake Notes:

THERAPY POLICY (revised 10/23/17)

We believe that a clear definition of our office policies is necessary in order to make the addition of Soft Tissue Therapies to your chiropractic care as easy as possible for you, the patient.

APPOINTMENT POLICY

Specific appointment times will be made for your Therapy at Somerset Hills Chiropractic (SHC.) Only the appointments that have been made either in person or on the phone with a member of the SHC staff can be honored.

If you are unable to keep an appointment time for any reason, we request that you call immediately to reschedule your visit. If you are going to be late for any reason, please call in advance so we can notify your Therapist.

There will be a $30 charge for all missed appointments, including those not cancelled at least 24 hours in advance. This charge is not billable to any third party insurance and must be paid by the responsible party out of your pocket.

On any of your visits that include soft tissue therapy, you will either receive your spinal adjustment before or after the therapy. Your chiropractic care is always your primary treatment and must not be missed if your insurance is to be billed for that day.

Therapy Appointments begin on the hour or half hour. The length of the appointments will allow for the patients to dress and the therapist to prepare the room for the next patient.

Your therapist will have specific knowledge of your diagnosis and the specific treatment objectives for your case.

If you have a standing appointment time and miss two consecutive appointments, **you may lose your time slot** so other patients can receive their necessary therapy.

FINANCIAL POLICY

All fees charged will be according to fee schedule. Any questions regarding changes and insurance assignment should be directed to staff members, not the Therapist.

It is our office policy that all services rendered are charged directly to you, the patient, and that you are ultimately responsible for all payments, regardless of whether or not this office accepts insurance assignment.

Tipping is not required, but appreciated.

SIGNED: _____ **DATE:** _____

PRINTED: _____