



Client Intake Form

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Male Female

E-mail: _____ Occupation: _____ Date of Birth: _____

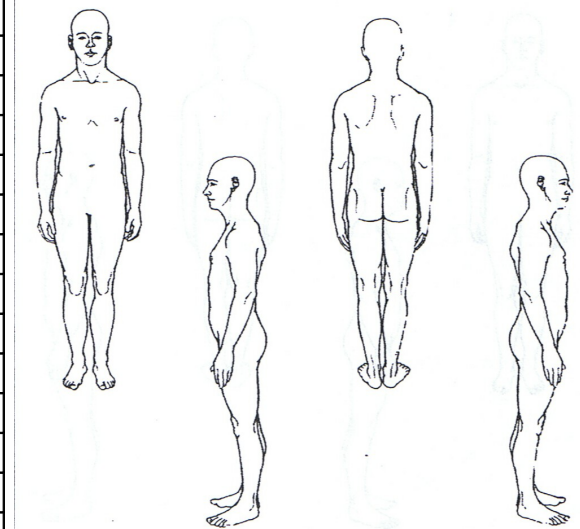
Referred by: phonebook webpage name: _____ other: _____

Emergency Contact & relationship to self: _____ Phone #: (____) _____

Have you experienced a professional massage/ body work session before? No Yes, when?: _____

General & Medical Information – Please check all that apply and note the approximate date of occurrence.

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Accident – Date:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Cancer – Type:	<input type="checkbox"/> Decrease Range of Motion
<input type="checkbox"/> Current treatment:	<input type="checkbox"/> Disk Problem
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Joint Ache	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Nervous Tension	<input type="checkbox"/> Stiffness
<input type="checkbox"/> Sprains	<input type="checkbox"/> Surgery
<input type="checkbox"/> Stroke	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Whiplash	<input type="checkbox"/> Stabbing Pain
<input type="checkbox"/> Numbness	<input type="checkbox"/> Headache
<input type="checkbox"/> Contagious Disease	<input type="checkbox"/> Stress
<input type="checkbox"/> Easily Bruised	<input type="checkbox"/> Medication – Type:
<input type="checkbox"/> Soreness	<input type="checkbox"/> Seizures
<input type="checkbox"/> Allergies:	<input type="checkbox"/> Other:



Please indicate your area(s) of pain/discomfort above.

Is there anything else that your therapist needs to be aware of? No Yes, explain: _____

I realize that this massage is being given for the health of my body and mind. This can include stress reduction, relief from muscular tension, spasm or pain, or increased circulation or energy flow. I agree to communicate with my practitioner any time I feel that my well being is compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage is not a substitute for medical examination or diagnosis. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status prior to future massage. **Initial** _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of The Massage Place. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment or

payment for services. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health care information. The Statement of Privacy Practices is also posted in the facility.

The Massage Place reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Initial _____

Missed Appointment Policy: If you do not call 24 hours before your scheduled appointment to cancel, then you will be responsible for paying The Massage Place for the missed appointment. **Initial** _____

Signature: _____

Date: _____