Massage Therapy Intake Form

Please read carefully and sign before receiving therapy. All information provided is confidential and will not be given out to anyone unless prior explicit permission is given. I understand that the massage I receive is provided for the purpose of relaxation and/or relief of muscular tension. If I experience any discomfort during the session, I will immediately inform the therapist so that the pressure and strokes may be adjusted. I understand that True Leaf Bodywork is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. I also understand that True Leaf Bodywork reserves the right to refuse or terminate sessions to anyone whom is considered to have a condition for which massage is contraindicated.

Client's Name____

Address ____

____

Referred by____

DOB ________________________ Phone #____

E-mail____

Insurance & Claims

Insurance Company____

ID #_______________________ Group #_____________________

Policy Holder's Name ____ DOB_____________________

PIP Only:

Claim Representative____ Phone__________________________

Claim # ______________________________ Date of Incident____

Emergency contact information:

Name____

Relationship______________________________________Phone____

Massage History

Reason for receiving massage____

____

Have you ever had a professional massage or other therapy before?__________How often?_______________

Please list any exercise or physical activity done on a regular basis. _____________________________________

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MEDICAL HISTORY

If you answer Yes to any of the following questions, please explain as clearly as possible:

Do you have any serious or chronic illnesses? ___Yes ___No

____

Are you taking any medication? ___Yes ___No

____

Do you have any skin conditions? ___ Yes ___No

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Do you have any allergies or sensitivities? ___Yes ___ No

____

Do you have high blood pressure? ____Yes____No

Do you have varicose veins or swelling? ____Yes____No

Do you have heart disease? ____Yes____No

Do you have pacemaker? ____Yes____No

Have you ever had a cardio-vascular surgery? ____Yes____No

Do you have migraines? ____Yes____No

Do you have any pain in your joints or arthritis? ____Yes____No

Do you suffer from epilepsy? ____Yes____No

Do you have diabetes? ____Yes_____No

Do you have asthma? ____Yes____No

Do you have any contagious diseases? _____Yes_____No

Do you suffer from claustrophobia? ____Yes____No

Have you ever or are you being treated for cancer? ___Yes ___No

Have you ever had any surgery and when? ___Yes ___No

____

Have you had any injures within last two years? ___Yes ___No

____

Are you pregnant or nursing? ____Yes____No

Are you currently being treated by physician? ____Yes ____No

Do you have any other medical issues I should know about? ____Yes ____No

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Consent & Release

The information I have given is true to the best of my knowledge, and I have not withheld any information concerning my health. It is my choice to receive massage therapy, and I give consent to receive treatment. I also give consent to release treatment notes and medical information to other members of my health care team as needed for insurance billing and continuity of care. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Client signature____date__________________

Parent/Guardian ____date__________________