client intake form

client signature

date of initial visit

personal information

name

address

city state zip

home phone cell phone

work phone

email

occupation

marital status

referred by

emergency contact name emergency contact phone

physician's name physician's phone

massage experience

Have you had a professional massage before? ❒ Yes ❒ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy?

Frequency of massages?

What are your goals for treatment?

current health

Do you exercise regularly and/or participate in any sports? ❒ Y ❒ N

If yes, what kind of exercise/sports?

Do you perform any repetitive movement in your work, sports or hobby? ❒ Y ❒ N

If yes, describe

Do you sit for long hours at a workstation, computer or driving? ❒ Y ❒ N

If yes, describe

Do you experience stress in your work, family, or other aspect of your life? ❒ Y ❒ N

If yes, describe

Are you experiencing tension, stiffness, discomfort or pain? ❒ Y ❒ N

If yes, describe

Have you recently had an injury, surgery, or areas of inflammation? ❒ Y ❒ N

If yes, describe

Do you have sensitive skin? ❒ Y ❒ N

Do you have any allergies to oils, lotions or ointments? ❒ Y ❒ N

If yes, please explain

List any medications you are currently taking

List any known allergies

health history

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify:
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive
___ Pregnant, stage
___ Ovarian/Menstrual Problems
___ Prostate

Skin
___ Allergies, specify:
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive
___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological
___ Anxiety/Stress Syndrome
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above :

This form was created as a resource by the american massage therapy association® and they are not held liable for any services provided.

client agreement & health release form

insurance information

client's full name _____ date _____

ins. ID # _____ date of injury _____

Is your condition the result of an auto accident? ❒ Yes ❒ No

If so, in what state did the accident occur? _____

❒ A work injury? ❒ A health condition? ❒ Other _____

What type of insurance do you have that may cover you for this condition? (*check all that apply*)

❒ Auto ❒ Workers' compensation/state Industrial ❒ Liability ❒ Health

Was a police/accident report filed? ❒ Yes ❒ No

Client's relation to insured? ❒ Self ❒ Spouse ❒ Partner ❒ Child ❒ Other

insured's full name _____

ins. IS # _____

date of birth _____

❒ Male ❒ Female ❒ Single ❒ Married ❒ Partnered ❒ Other

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____

employer's name/school name _____

address _____ phone _____

primary insurance plan name _____

group number _____ plan number _____

phone _____

plan's billing address _____

city _____ state _____ zip _____

secondary insurance information

who is your attending physician? _____ name _____

address _____

city _____ state _____ zip _____

office phone _____ fax _____

Permission to consult with _____ regarding _____ Your initials _____

Has an attorney been retained? ❒ Yes ❒ No

name _____

address _____

city _____ state _____ zip _____

home phone _____ work phone _____

fax _____

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 understand that the american massage therapy association® has provided this form as a reference and is not held liable for any services provided.

signature _____ date _____

assignment of benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature _____ date _____

signature of parent or legal guardian (if client if a minor) _____

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

signature _____ date _____

signature of parent or legal guardian (if client if a minor) _____

(*Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.*)

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. 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.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature _____ date _____

signature of parent or legal guardian (if client if a minor) _____

This form was created as a resource by the american massage therapy association® and they are not held liable for any services provided.