Massage Therapy Intake Form

Date: ____________

Name ______________________________ Date of Birth ____________ Ph ____________________

Address __________________________________ City ___________________ St _____ Zip _______

Have you ever received a professional massage? *No* *Yes* If yes, how often? ______________________

What results would you like from your massage? ____

____

Prioritize the areas of your body you would like to have massaged: ________________________________

____

Are you currently seeing a medical practitioner? *No* *Yes* If yes, please explain: ____________________

____

Stress reduction and exercise activities, including frequency: ______________________________________

____

Current Medications: ____

Surgery History: ____

____

Accident History: ____

Circle all that apply:

Musculo-Skeletal
Bone or joint disease
Tendonitis
Bursitis
Broken/Fractured bones
Arthritis
Low back/Hip/Leg Pain
Neck/ Shoulder/Arm Pain
Headaches/Head Injuries
Spasms/Cramps
Jaw Pain/TMJ
Other ____________________

Skin
Allergies
Rashes/Athlete's Foot
Warts
Other ____________________

Circulatory
Heart Condition
Varicose Veins
Blood Clots
High Blood Pressure
Low Blood Pressure
Lymphedema/Swelling
Breathing Difficulty
Sinus Problems
Allergies
Cancer/Tumors Fatigue
Other ____________________

Nervous System
Herpes/Shingle
Numbness/Tingling
Chronic Pain
Fatigue
Sleep Disorders
Other ____________________

Digestive
Constipation
Gas/ Bloating
Irritable Bowel Syndrome
Other ____________________

Reproductive
Pregnant: ____ months along
PMS
Menopause
Other ____________________

Other Diseases
Diabetes
Depression
Nicotine Addition
Caffeine Addiction
Eating Disorder
Drug/Alcohol Addiction
Other ____________________

OVER →

Massage Informed Consent - Please read carefully and sign below

Licensed Massage Therapist's adhere to a code of conduct intended to provide a safe, confidential, professional and therapeutic environment. If you have any concerns or questions, please bring them to the Massage Therapist's attention.

I, the client, understand that massage therapy is provided for the basic purpose of relaxation and relief of muscular tension. This process breaks up the pain cycle in my body, but in doing so, my body may require time to adjust to these physiological changes. If any pain or discomfort is experienced during session, I will immediately inform the massage therapist so that the pressure, temperature and/or strokes may be adjusted to my level of comfort.

Male/Female genitalia and women's breasts will not be exposed or massaged at any time. Modest draping will be used during the session – only the area being worked on will be uncovered. Sexual misconduct including suggestive commentary will not be tolerated. Massage therapy services may be terminated at any time if client's behavior is deemed inappropriate by massage therapist and vice versa. **Initial here that you have read the Sexual Misconduct statement** ______

It is the massage therapist's sole discretion, to refuse or discontinue massage therapy services at any time if they determine such services may be unsafe, and/or cause discomfort to the client. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage therapy should not be performed under certain medical conditions, I understand, acknowledge and voluntarily accept the risks associated with massage services. The most common risks of massage include, mild, short-term muscle soreness and/or surface level bruising. I understand that massage therapy is not an exact science. No promises or guarantee have been made, or can be made about the success or outcomes of massage therapy. I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated with any changes in my health and understand that there shall be no liability on the part of the massage therapist or Discover Chiropractic due to failure to disclose any pre-existing condition, limitation or sensitivity.

Clients under the age of 18 must have informed, written consent and be accompanied by a parent or legal guardian during the entire session.

If I am a chiropractic patient, I grant permission for the massage therapist to access my chiropractic health information. This helps the massage therapist gain greater knowledge of my biomechanics structure, thus improving my care.

I acknowledge that I have read and understand the above information.

Client/Parent/Legal Guardian Signature: ________________________________ Date: _________

Financial Policy Acknowledgment

Discover Chiropractic is committed to providing the best treatment for patients and charging what is usual and customary for the Marquette, Michigan area.

Please discuss your insurance benefits with staff prior to selecting one of the following:

☐ I give permission for claims submission to my insurance company on my behalf and assign all benefit payments to Dr. Craig Thomas. I further give permission for the disclosure of my healthcare information to my insurance company for the purposes of obtaining payment for services and determining insurance benefits. Benefits quoted are an estimation of coverage, are subject to change and are not a guarantee of payment. ***I understand that I am responsible for tracking my yearly visit limit maximum as dictated by my insurance company. I am aware that some or all of the services I receive may not be covered by my insurance and I am financially responsible for all non-covered costs beyond reasonable and customary as defined by my insurance company.***

☐ I choose to pay out of pocket. Insurance will not be billed.

I agree that I am financially responsible for payment on my account in a timely manner.

I understand Discover Chiropractic is authorized to add 10% interest to my account monthly if my balance is overdue and/or my account becomes inactive. Accounts over 90 days past due will be considered for submission to a collection company and will be subject to additional fees to cover cost of that service.

I affirm that I have read and understand the above information in its entirety and that all my questions regarding the financial policy and my insurance policy have been answered to my satisfaction. I intend this financial consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient Signature: ____ Date: ___________

Is the patient **Financially Responsible** for this account? *yes* *no* If **no**, then complete below:

Financially Responsible Party (Print): ______________________________________ Ph: ______________

Address: ______________________________________ City ____________________ St ___ Zip _______

Signature: ____ Date: __________________

I give permission to the office to discuss insurance/financial matters with the insurance policy holder and/or person financially responsible for this account (circle one): ***yes no***

Privacy Practices Acknowledgment - I affirm that I have read the Notice of Privacy Practices form in its entirety. I understand the information and all my questions regarding the privacy policy have been answered to my satisfaction. I intend this privacy consent to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Signature: ____ Date: ____________________