Massage Intake Form

Name____ Male ____ Female ____ Date ________________

Address_______________________________________ City/State/Zip ___________________________

Date of Birth______________ Email Address ____

Home Phone ______________________ Cell Phone ______________________ Work Phone ___________________

Emergency Contact _______________________________ _____________________ ______________________

Name *Relationship* *Phone*

Occupation ____ full-time ___ Part-time ___

How did you hear about us? ____

Please answer the following to the best of your knowledge.

1. What is the goal(s) for your visit today? ____
2. Have you had a professional massage before? ___ Yes ___ No

   If yes, what did you like about it? ____

   Was there anything you didn't like about it? ____

   Preferences: Starting position: ___ Face-up ___ Face-down ___No Preference

   Heat: ___ Yes ___ No ___ No Preference Pressure: ___Light ___ Medium ___ Firm
3. Are you allergic to nuts, oils, lotions or any other substances put on your skin? ___ Yes ___ No
4. Do you have any health concerns? Yes No If yes, please explain: _________________________

   ____
5. Medications for: (X if applies): ___ Pain ___ Low blood pressure ___ Insulin ___ Chemo ___ Radiation
6. Please describe any surgeries or injuries you have had that may relate to your current symptoms: ______________

   ____
7. Please circle your stress level: Low 1 2 3 4 5 High. How do you relieve your stress or pain? ____________

   ____
8. Do you exercise? ___Yes ___No Frequency ___/wk Please circle one: Light Moderate Heavy
9. How is your diet: Very Good Good Not So Good
10. Please list your two most bothersome issues today: (example – Right shoulder pain or Left knee pain)
    1. ________________________________ Rate pain level: Low 1 2 3 4 5 6 7 8 9 10 High

       Briefly describe symptom ____

       What makes symptom better/worse? ____
    2. ________________________________ Rate pain level: Low 1 2 3 4 5 6 7 8 9 10 High

       Briefly describe symptom ____

       What makes symptom better/worse? ____

11. Is there anything else you feel your therapist should know?

____

____

12. Are you interested in receiving information about our health coaching services? ___ Yes ___ No

Please circle any conditions that apply to you, past and present. Please add comments to clarify the condition.

Musculo-Skeletal
Headaches/ Migraines
Joint stiffness/ swelling
Spasms/ cramps
Broken/ Fractured bones
Strains/ Sprains
Artificial Joint
Scoliosis
Fibromyalgia or CFS
Rheumatoid Arthritis
Arthritis
Whiplash
Jaw pain/ TMJ syndrome
Tendonitis
Bursitis
Plantar Fasciitis
Osteoporosis
Other: _______________

Circulatory/Respiratory
Dizziness/ Fainting
Shortness of breath
Cold sweats/ hot flashes
Cold hands / feet
High / Low Blood Pressure
Asthma
Stroke
Heart Condition
Deep Vein Thrombosis
Allergies
Other: _________________

Digestive
Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Ulcers
Other: _______________

Nervous System
Parkinson's Disease
Numbness/tingling
Fatigue
Sleep disorders
Paralysis
Alzheimer's
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Other: ________________

Reproductive System
Pregnancy
Other: _________________

Skin
Rashes/ Burns/ Boils
Allergies
Athlete's foot
Cold Sores/ Herpes
Impetigo
Warts/ Wounds/ Open Sores

Other
Loss of appetite
History of blood clots
Easy Bruising
Depression/Anxiety
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Edema
Neuropathy
Tuberculosis
Post/Polio Syndrome
Cancer
Lymphodema
Other: ______________

Massage Therapy Disclosure

I understand massage therapy should not be construed as a substitute for a medical examination, diagnosis, or treatment and I should see a physician or other qualified medical specialist for any mental or physical ailment deemed necessary. I am also aware anything said during the session should not be construed as an examination, diagnosis, treatment or cure. I understand massage practitioners are not qualified to perform spinal or skeletal adjustments.

I affirm I have stated all known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any change in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand the practitioner is a professional and will handle all aspects of the session as so, protecting privacy and boundaries at all times and providing a safe environment. By signing below I agree to the above conditions and have received a copy of MSWP's Bill of Rights and HIPAA forms.

Massage Appointment Cancellation/Rescheduling Policy

-Please arrive at least 10 minutes before your scheduled appointment time in order to ensure a full massage session.

-If you should show up late for your scheduled massage time, it will cut into full massage session.

-You may cancel or reschedule your appointment without charge up to 24 hours prior to your appointment time.

-Rescheduling your appointment within 24 hours will be charged 50% of the scheduled service price.

-If you cancel your appointment within 24 hours or do not show up for you scheduled appointment, you will be charged full price for the scheduled service.

-A valid credit card number or redemption code is required to schedule a massage. The credit card or redemption code provided will be charged if client does the following stated above.

Client Signature ____ Date: ____________

Therapist Signature ____ Date: ____________

Complementary and Alternative Health Care
Client Bill of Rights

Certified Massage Therapist, 13352 Aberdeen Street NE Suite A, Ham Lake, MN 55304, 763-786-5585

As of July 1, 2001, revise August 2008, Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive and acknowledge, by your signature on the bottom of this page, that you have received the following information prior to your treatment.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR YOUR INFORMATION PURPOSES ONLY.

Personal Interaction: You have the right to expect courteous treatment, free from verbal, physical or sexual abuse.

Right to Refusal: You have the right to refuse services or treatment, unless otherwise provided by law.

Coordinated Records Transfer: You have the right to coordinated transfer of your records when there will be a change in the provider of services.

Right of Non-retribution: You have the right to assert any and all of the above rights without retaliation from the practitioner.

Concerns or Complaints: As a client you have the right to file a concern or complaint with your practitioner's supervisor. To do so, you may call, email or write to the following addresses:

Certified Massage Therapist
763-786-5585
blainefamilychiropractic@gmail.com

Office of Complementary and Alternative Health Care Practice
Health Occupations Program MN Dept of Health
(651) 282-5623
PO Box 64975, 121 East 7th St Suite 400
St. Paul, MN 55164-0975

Right to Confidentiality: Client records are confidential and will not be released, unless authorized by you in writing or as otherwise provided for by law.

I, ______________________________, acknowledge by my signature that I have received and understand the Complementary and Alternative Health Care Member/Client Bill of Rights.

Client Signature ____ Date _____________
Practitioner Signature ____ Date ________

HIPPA

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

MY PRIVACY PLEDGE: Our Massage Therapists are concerned with and committed to the protection of their clients' privacy and ensuring the confidentiality of personal health information entrusted to them. With your written permission, the Massage Therapist may use or disclose your health care information to include, but not limited to:

- Another health care provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as a contracted service provider, insurance carrier or employer for the purpose of receiving payment for services rendered to you.
- Within our practice for quality control or other operational purposes.
- The use of that information to contact you by phone, mail or email with appointment reminders, information about our services or other health-related information that may be of interest to you.

I reserve the right to change my privacy practices at my discretion to remain in compliance.

Your Right to Limit Uses or Disclosures: You have the right to request that I do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let me know in writing. I am not required to agree to your restrictions; however, if I agree with your restrictions, the restriction is binding on me.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if I already released your health information before receiving your revoke request in writing. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

By signing below, I give consent to disclose my personal health information for the reasons listed above.

Client Signature____ Date _______________

Practitioner Signature____ Date ______________