Massage and Bodywork Confidential Intake Form

Please complete this document as accurately as possible. Some questions may seem unrelated to your condition; however they play a role in your treatment plan.

Client Contact Information

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Ph:_____Cell Ph:_____ Wk Ph:_____

Occupation:_____Employer_____

Age:_____ Birth Date_____/____/_____

*Email:_____

Your email will never be given out to another party.

Emergency Contact Name and Number:_____

Insurance Information

Primary Insurance Company:_____

Group Number:_____ ID Number:_____

Subscribers Name:_____ DOB:_____

Social Security Number:_____ Relation to Patient:_____

Physician Information- Please note, we will only bill insurance with a prescription from a medical provider. (MD, DC, PT, PA, NP or DO preferred**) It must include a frequency, duration and diagnosis code(s).**

Physician's Name:_____Type of Physician_____

Do I have permission to contact your healthcare provider if needed? ____yes ____no

Notice of Privacy Practices

I acknowledge that I was provided the opportunity to review the LifeTouch Massage and Wellness, Ltd notice of privacy practices.

Signature of Client/Responsible Party:_____

Current Medical Information

Are you currently under a doctor or health practitioner's care for any medical condition(s), illness or injury? No / Yes If so, please explain_____

Is there any chance you are pregnant or are trying to conceive? No / Yes
If pregnant, how many weeks?_____ Any concerns or complications?_____

Do you wear contacts? No / Yes Dentures? No / Yes Hearing Aids? No / Yes Hair piece? No / Yes

Are you taking any pain relievers or anti-inflammatory meds? No / Yes
If yes, please list the medication and the time of your last dose_____

Are you taking any blood thinning medications or medications that make you bruise easily? No / Yes

Please list your medications, vitamins, and/or supplements (dosage not required)
_____
_____

Please list ANY allergies you have to medications, food, lotions or oils:_____
_____

MEDICAL HISTORY

All of this information is strictly confidential and cannot be shared with anyone by law. Please include any recent rashes, bruises, bumps, breaks, sprains, strains, fractures, illnesses or surgeries.

___Abscess/open sore/surgical site
___Allergies
___Arteriosclerosis
___Asthma
___Bruise easily
___Cancer/undiagnosed lump
Type_____
Location_____
Treatment type(s)_____
Lymph nodes removed or treated
___Depression
___Diabetes
___Digestive problems i.e., IBS, reflux
___Epilepsy
___Fibromyalgia
___Fibrosis
___Fluid Retention
___Headaches
___Heart Conditions
___Herniated/ruptured disc
___Hepatitis
___Herpes
___History of mental illness
Physical or emotional abuse, counseling/therapy
___HIV/AIDS
___Hypertension
___Inner ear problems
___Insomnia
___Other (including past injuries that still affect you)
___Implants
Where?_____
___Lupus
___Phlebitis
___PMS / cycle difficulty
___Pregnancy (current)
___Post Traumatic Stress
___Osteoarthritis
___Osteoporosis
___Rheumatoid arthritis
___Skin sensitivity
___Sleep apnea
___ Varicose veins
___ Vision problems

_____

Are you here for treatment of Lymphedma? No/Yes If Yes: When were you Diagnosed?_____

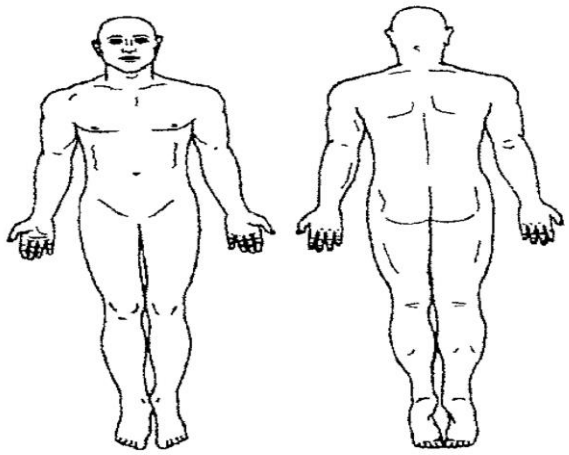
What types of treatment have you had in the past to manage your swelling?
_____
_____

Have you ever had a massage before? No / Yes

What are your current symptoms/issues?_____

What treatments have you received for your symptoms?_____

Please mark your areas of focus: Are there any areas that you want avoided during your massage?



Here are some abbreviation letters you can use to mark the areas:

X= area of focus today
N= numbness
T= tingling
B= burning
A= aching
S= sharp
I= injury site

Any additional details you would like to provide: _____

_____

_____

_____

Please read the following and sign below:

I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

1. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

2. I understand that massage should not be performed under certain medical conditions and I affirm that I my answers pertaining to any medical condition(s) and history have been answered truthfully.

Client Signature_____Date_____