Abandon Your Aches Massage
Intake Form

Name: ______________________ Date: ____________ Birth Date: ________

Address: ______________________ City: ____________ State: ____ Zip: ______

Phone: ________________ E-Mail: ______________________

May I contact you at the above Phone: **Y** or **N** If **no**, how may I contact you? ____________
If I leave message, can I include: **appt info** or **call-back # only**

Employer: ________________ Work Phone: __________ May I contact you here? Y N

Emergency Contact/Relationship: ________________ Phone: __________

How did you hear about me? ______________________

Health History

Doctor: __________ Clinic: __________ Phone: ______________

What do you see your Dr. for? ______________________

Are you currently taking any substances? If so, please list below (Include herbs, homeopathic remedies, supplements, alcohol, recreational drugs and prescribed medications):

Please list any surgeries, injuries, or accidents (auto, skiing, horse, etc.) you've had:

Type of Injury/Surgery/Accident	Brief Description	Date

Please indicate and briefly explain history with the following (C=Current, P=Past, N=No):

General Systems

C P N Cardiovascular
(Heart, Blood Vessels, Blood, etc.)

C P N Endocrine
(Diabetes, Hypoglycemia, Hypothyroidism, etc.)

C P N Gastrointestinal
(Ulcers, Gastritis, Chron's Disease, Hepatitis, Gallstones, Pancreatitis, etc.)

C P N Immune
(HIV, AIDS, swollen glands, cold/flu, etc)

C P N Musculoskeletal
(Muscles & bones: osteoporosis, sprains, fibromyalgia, etc.)

C P N Neurological
(MS, Carpal Tunnel, etc.)

C P N Psychological
(PTSD, depression, bipolar disorder, etc)

C P N Reproductive
(PID, endometriosis, UTI, STD's, etc.)

C P N Respiratory
(Bronchitis, pneumonia, cystic fibrosis, emphysema, etc)

C P N Urinary
(Bladder/Kidney infections, etc)

C P N Integumentary (Skin)
(Acne, athlete's foot, herpes, etc.)

Specific Conditions

C P N Allergies (please list) __________
C P N Arthritis
C P N Diabetes
C P N Hypertension
C P N Osteoporosis
C P N Cancer (type/date) __________
C P N Other (please specify) __________

General Health

C P N Stress
C P N Headaches
C P N Fever
C P N Inflammation/Swelling
C P N Pain
C P N Numbness
C P N Pregnancy
C P N Menstrual (pain)
C P N Abnormal Energy
C P N Sleep Problems
C P N Dietary Problems
C P N Communicable Disease

Have you had massage before? Y N Frequency: __________ For: __________

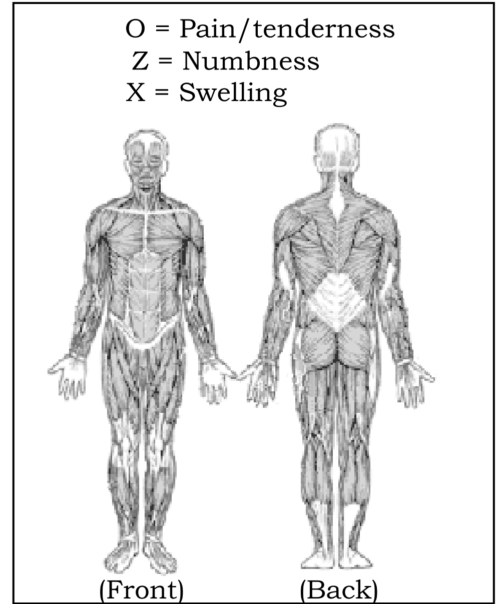
What were the results? ______________________

Name: ______________________________ Date: ____________________

Today's Massage:

What would you like from your massage today?
(Include areas you'd like specific attention or avoided)

O = Pain/tenderness
Z = Numbness
X = Swelling



(Front) (Back)

Please also indicate severity of symptoms from 1-10
(1=I feel great, 10=I'd take child birth/kidney stones any day)

1 2 3 4 5 6 7 8 9 10

Is condition generally becoming ___ worse ___ better ___ same

Is there an activity that makes the symptoms worsen or subside?

Does your job or recreational activities affect the symptoms?

How often do you have these symptoms?

What is your ultimate goal for massage (even if it takes more than one session)?

Are you wearing contacts? (The face cradle may cause pressure on your eyes)

Consent for Care:
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 or 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.

Signature ______________________________ Date ____________________

Auto Accident Info: (Fill out only if this applies to you)

What type of impact: _____ Hit from behind ______Hit on L / R side _______ Front _______Rollover

What area of your vehicle was damaged ______________________________

What was the approximate speed? Your vehicle______ other vehicle/object_______

Did you go to the ER? Y N What tests/x-rays were performed________________________

Besides Dr. referring you here and/or the ER, have you seen any other providers? If so, who?

____

Were there any results that would affect your massage?

____

____

Insurance Information

Client Full Name______________________________ Date_____________ Date of Injury _____________________

Condition Result of: ___Auto Accident, ___Work Injury, ___Health Condition, ___Other ______________

What type of Insurance do you have that may cover you for this condition? (Mark all that apply)
___Auto ___Workers' Compensation/State Industrial ___Liability

Was Police Report Filed? ___ Yes ___No

Client's Relation to Insured? Self / Spouse / Partner / Child / Other
Insured's full name _____________________________________ Ins. ID# ______________________
DOB ______________ M / F Single/Married/Partner/Other
Address_________________________________ City_______________________ State________ Zip___________
Phone – Home _________________________ Work______________________ Cell/Pager__________________

Insurance Company ____
Policy # ___________________ Claim #______________________ Phone _____________________
Plan's billing address____
Insurance Company Contact Name/Phone:____

Referring Physician ____
Address________________________________ City________________________ State________ Zip___________
Office Phone___________________ Fax____________________
Permission to consult with above listed referring physician regarding claim care: Initials__________

Has an attorney been retained ___Yes ___ No Name____
Address________________________________ City________________________ State_________ Zip___________
Office Phone_____________________________ Cell Phone________________________ Fax__________________

Assignment of Benefits
I am responsible for all charges for all services 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 will not be asked to pay the balance

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

Signature____ Date__________________
Signature of parent or legal guardian (if client is minor)

Release of Medical Records
I authorize the release of my 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 is 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 session's plan based upon the information provided by my massage therapist. I agree to participate in my own self-care program 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 skill and knowledge.

Signature____ Date__________________
Signature of parent or legal guardian (if client is minor)