

# 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):

- |   |   |
|---|---|
| <p><b><u>General Systems</u></b></p> <p>C P N <b>Cardiovascular</b><br/>(Heart, Blood Vessels, Blood, etc.)</p> <p>C P N <b>Endocrine</b><br/>(Diabetes, Hypoglycemia, Hypothyroidism, etc.)</p> <p>C P N <b>Gastrointestinal</b><br/>(Ulcers, Gastritis, Chron's Disease, Hepatitis, Gallstones, Pancreatitis, etc.)</p> <p>C P N <b>Immune</b><br/>(HIV, AIDS, swollen glands, cold/flu, etc)</p> <p>C P N <b>Musculoskeletal</b><br/>(Muscles &amp; bones: osteoporosis, sprains, fibromyalgia, etc.)</p> <p>C P N <b>Neurological</b><br/>(MS, Carpal Tunnel, etc.)</p> <p>C P N <b>Psychological</b><br/>(PTSD, depression, bipolar disorder, etc)</p> <p>C P N <b>Reproductive</b><br/>(PID, endometriosis, UTI, STD's, etc.)</p> <p>C P N <b>Respiratory</b><br/>(Bronchitis, pneumonia, cystic fibrosis, emphysema, etc)</p> <p>C P N <b>Urinary</b><br/>(Bladder/Kidney infections, etc)</p> <p>C P N <b>Integumentary (Skin)</b><br/>(Acne, athlete's foot, herpes, etc.)</p> | <p><b><u>Specific Conditions</u></b></p> <p>C P N Allergies (please list) _____</p> <p>C P N Arthritis _____</p> <p>C P N Diabetes _____</p> <p>C P N Hypertension _____</p> <p>C P N Osteoporosis _____</p> <p>C P N Cancer (type/date) _____</p> <p>C P N Other (please specify) _____</p> <p><b><u>General Health</u></b></p> <p>C P N Stress _____</p> <p>C P N Headaches _____</p> <p>C P N Fever _____</p> <p>C P N Inflammation/Swelling _____</p> <p>C P N Pain _____</p> <p>C P N Numbness _____</p> <p>C P N Pregnancy _____</p> <p>C P N Menstrual (pain) _____</p> <p>C P N Abnormal Energy _____</p> <p>C P N Sleep Problems _____</p> <p>C P N Dietary Problems _____</p> <p>C P N Communicable Disease _____</p> |
|---|---|

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)

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)?

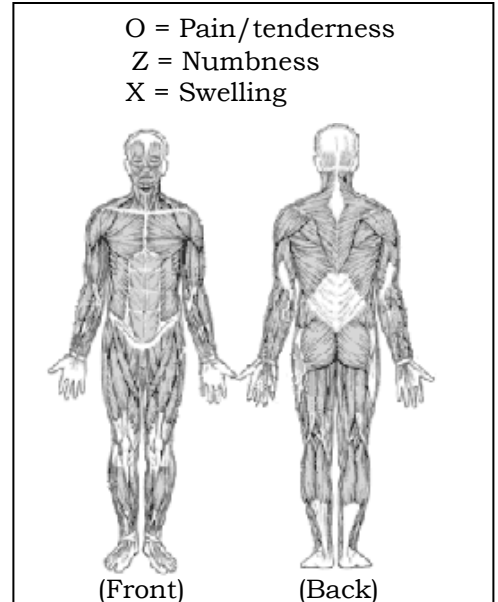
Are you wearing contacts? (The face cradle may cause pressure on your eyes)

**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 Moog, 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)