HEALING MASSAGE PLLC

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Client Intake Form

Contact Information:

Name: _____ Date of Birth: _____Gender: ☐Male ☐Female ☐Other

Phone:(_____) _____ Preferred Communication: ☐Call ☐Text ☐Email

Email: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Massage/Health Information:

Have you received a professional massage before? ☐No ☐Yes → How long since your last massage? _____

Are you allergic or have any sensitivities to essential oils, creams, or lotions? ☐No ☐Yes

What kind of pressure do you prefer? ☐Light ☐Medium ☐Firm

What is your goal/expected outcome for receiving massage/bodywork? _____

Is there anywhere you **DO NOT** want to be massaged? (i.e., Face, head, feet) _____

Do your symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, walking, childcare)? ☐No

☐Yes Please explain: _____

Please indicate conditions that you **HAVE** currently or **HAVE HAD** in the past. Explain in detail, including the treatment received:

- ○ **Current** ○ **Past** Contagious Disease
- ○ **Current** ○ **Past** Cancer (Where? How long ago?)
- ○ **Current** ○ **Past** Blood Clots
- ○ **Current** ○ **Past** Neurological (e.g., MS, Parkinson's)
- ○ **Current** ○ **Past** Diabetes
- ○ **Current** ○ **Past** Epilepsy, seizures
- ○ **Current** ○ **Past** Stroke (How long ago?)
- ○ **Current** ○ **Past** Heart attack (How long ago?)
- ○ **Current** ○ **Past** Congestive heart failure (How long ago?)
- ○ **Current** ○ **Past** Kidney disease, infection
- ○ **Current** ○ **Past** Endocrine/thyroid conditions
- ○ **Current** ○ **Past** High/Low blood pressure
- ○ **Current** ○ **Past** Varicose Veins
- ○ **Current** ○ **Past** Arthritis (rheumatoid, osteoarthritis)
- ○ **Current** ○ **Past** Osteoporosis, degenerative spine/disk
- ○ **Current** ○ **Past** Broken bones (Where? How long ago?)
- ○ **Current** ○ **Past** Skin Disorders (Warts, boils, acne, impetigo, herpes simplex, tinea, scabies)
- ○ **Current** ○ **Past** Whiplash (How long ago?)
- ○ **Current** ○ **Past** Yeast or Fungal Infection (Athletes foot, Ringworm)
- ○ **Current** ○ **Past** Allergies (nut allergies, sensitive skin)
- ○ **Current** ○ **Past** Edema (swelling)
- ○ **Current** ○ **Past** Pitted Edema
- ○ **Current** ○ **Past** Depression, anxiety
- ○ **Current** ○ **Past** Dizziness, ringing in the ears
- ○ **Current** ○ **Past** Headaches, Migraines
- ○ **Current** ○ **Past** Shortness of breath, asthma

○ **Current** ○ **Past** Digestive conditions (e.g., Crohn's, IBS)
○ **Current** ○ **Past** Scoliosis

○ **Current** ○ **Past** Bruise easily
○ **Current** ○ **Past** Muscle or joint pain

○ **Current** ○ **Past** Muscle or Joint Stiffness
○ **Current** ○ **Past** Numbness or tingling
○ **Current** ○ **Past** Sprains or Strains (Where? How long ago?)
○ **Current** ○ **Past** Memory loss, confusion (easily overwhelmed)
○ **Current** ○ **Past** Degenerative Disc/Spinal Fusion (Where? How long ago?

Anything we may have forgotten? Please list below:

_____

Is there a chance you could be Pregnant? ☐ No ☐ Yes →How far along: _____

Any high risk factors? Please explain: _____

Are you taking any medications or supplements? Please list and explain their purpose:

_____

Is this massage/bodywork medically necessary (is it from a medical condition, injury, or surgery)? ☐ Yes ☐ No

Explain: _____

Insurance Information

Do you have a physician referral/prescription? ☐ No ☐ Yes

Are you seeking insurance reimbursement? ☐ No ☐ Yes

Type of insurance coverage for this claim: ☐ Car Collision ☐ Workers Compensation

Claim Number: _____ Adjuster: _____ Phone: _____

Do you have a private health insurance ☐ No ☐ Yes

Subscriber Name: _____ Date of Birth: _____

Phone Number if different than above: _____

Insurance company: _____

Provider phone number:_____

Insurance ID# (include alpha prefix): _____

OFFICE STAFF USE ONLY Date: _____ Time: _____

☐ IN NETWORK ☐ OUT OF NETWORK Insurance Representative:

Reference #: _____

Are there out-of-network benefits available? ☐ Yes ☐ No Does the treatment have to be pre-authorized? ☐ Yes ☐ No

Does the insurance plan cover massage therapy? ☐ Yes ☐ No Does the treatment have to be referred? ☐ Yes ☐ No

What is the annual massage therapy benefit # visits _____/_____ -OR- $_____/$_____?

What is the deductible? $ _____ Remaining? $_____

Is there a Copay? $_____ Co-Insurance _____%

Please read carefully!

Medical Release

- I hereby **authorize the release of medical information necessary to process my insurance claim**. This may include intake forms, chart notes, reports, correspondences, billing statements, and any other information to my attorneys, health care providers, and insurance case managers.

Office Policies & Consent to Service

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and increased circulation. I further understand that **massage should not be construed as a substitute for medical examination, diagnosis, or treatment** and that I should see a physician, chiropractor, or other qualified medical specialists for any mental or physical ailment of which I am aware.

- Because massage should not be performed under certain medical conditions, I affirm that I have stated **all of my known medical conditions and answered all the questions honestly.** I agree to keep the practitioner updated on any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

- **If I experience any pain or discomfort during this session**, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

- I also understand that **any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session,** and I will be liable for payment of the scheduled appointment.

- **Please arrive on time for your service** so you can receive your full amount of hands-on time. Your message will end on time so that the next client is not inconvenienced, and the full treatment price will apply. If we are running late, you will still receive your full amount of scheduled time.

- **A 24-hour cancellation notice is required.** All no-call/no-shows will be charged **$50.** If you are using a gift certificate, rather than being billed, your massage will be considered as having been used.
- **Please note: verification does not guarantee coverage. If your claim is denied, you'll be responsible for full payment.**
- As a patient of this office, you are responsible for all charges incurred. If your auto insurance claim or L&I claim is not open and payable, or your medical insurance denies payment. you will be required to pay out of pocket for your visit(s).
- **A late-Payment Penalty** of $10.00 applies after each invoice payment due date.

Print name _____

Client Signature (Parent/Guardian): _____Date: _____

UNDER 18 ☐ Yes ☐ No

Client Signature (Parent/Guardian): _____Date: _____

Consent to Treat Form

- I _____ (patient name) give permission for *Healing Massage PLLC* to give me medical treatment.
- I allow *Healing Massage PLLC* to file for insurance benefits to pay for the care I receive.
  I understand that:
  1. *Healing Massage PLLC* will have to send my medical record information to my insurance company.
  2. I must pay my share of the costs.
  3. I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.
- I understand:
  1. I have the right to refuse any procedure or treatment.
  2. I have the right to discuss all medical treatments with my clinician.

Print name _____

Client Signature (Parent/Guardian): _____Date: _____

UNDER 18 ☐ Yes ☐ No

Client Signature (Parent/Guardian): _____Date: _____