Massage Intake Form

Date:_____

Patient Information:

Last Name: _____ First Name:_____ Middle Initial: ___
Date of Birth: _____ Sex: □ Male □ Female
Address:_____
City: _____ State: _____Zip:_____
Home Phone:_____Cell Phone: _____
Preferred Method for Reminder Calls: □ Home □ Cell (Circle: Voice or Text) □ Email
Email: _____Referred By:_____
Do you see a Chiropractor? □ Yes □ No
If yes, Whom? _____
Occupation:_____

Emergency Contact:

Name: _____
Contact Phone Number: _____Relationship: _____

Health Insurance Information (If you have verified massage coverage):

Responsible Party for Insurance:_____
Relationship to Patient:_____
Insurance Carrier: _____ID #: _____Group #: _____
Effective Date: _____
Is there secondary insurance? □ Yes □ No
If yes, Insurance Carrier: _____ID #: _____Group #: _____
Do you need a referral or preauthorization for coverage? □ Yes □ No
Referring Physician:_____ Date of referral:_____
Referral Expiration Date:_____
If referral is needed, please give a copy to the receptionist.

Special Claim Accident: □ Work □ Auto

Your Insurance Carrier: _____
Claim #: _____
Adjuster's Name:_____
Telephone #: _____Extension: _____
Date of Accident:_____
State of Accident:_____

Camas Family Health Center
235 NE 6th Avenue, Camas, Washington 98607
Phone: (360) 834-5126 Fax: (360) 838-1582
Dustin Brubaker, LMP – Kitrina DePaolo, LMP – Kris Good, LMP
Elizabeth Loop. LMP – Samantha VanDinter, LMP

Massage Intake Form (cont.)

Patient Questions:

What is your major symptom/problem?

_____

Have you ever had a professional massage before? □Yes □No
Do you have difficulty laying on your front, back or side? □ Yes □ No
If yes, which causes you difficulty?_____
Do you wear the following? □ Pacemaker □ Insulin Pump
Are there any areas you **DO NOT** want massaged? If so, please list below:

_____

What type of pressure do you prefer? □ Light □ Moderate □ Deep □ Not Sure

Health History

Are you under medical supervision? □ Yes □ No
If Yes, please explain:_____
Are you currently taking any medications? □ Yes □ No
If Yes, please list:_____
Primary Health Care Provider: _____Telephone #:_____

Check the following conditions that apply to you, past and present.

□ Aids/HIV
□ Allergy to Oils/Lotions/Fragrances What?_____
□ Anxiety/Depression
□ Arm/Shoulder Pain
□ Arthritis
□ Artificial Joints
□ Auto Accident, When?_____
□ Back Pain
□ Bruise Easily
□ Circulatory Problems
□ Communicable Diseases, What?_____
□ Current Fever
□ Deep Vein Thrombosis
□ Diabetes
□ Epilepsy
□ Flu/Cold
□ Pregnant, how many weeks?_____
□ Recent Surgeries, When?_____
□ Other _____
□ Heart Disease
□ High/Low Blood Pressure
□ Leg Pain
□ Neck Pain
□ Nervousness
□ Open Sores/Wounds
□ Osteoporosis
□ Headaches
□ Cancer
□ Seasonal Allergies
□ Shingles
□ Skin Disease
□ Thyroid Problems
□ TMJ/Jaw Issues
□ Varicose Veins
□ Sciatica

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Massage Intake Form (cont.)

Patient/Provider Agreement

I understand the massage/bodywork I receive is provided for basic purpose of relaxation and relief of muscular tension, spasm or pain. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see my primary health care provider or other qualified medical specialist for such services. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe pharmaceuticals or treat any physical or mental illness. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered questions honestly and to the best of my knowledge. I agree to keep the Practitioner updated as to any changes in my medical profile and understand there shall be no liability on the Practitioners part should I forget to do so. Insurance quotes are not a guarantee of payment and if my insurance/attorney does not pay for services rendered, I agree to pay the therapist in full for all treatments. **It is advised that I give at least 24 hours cancellation notice, not doing so I will incur a $30 no show fee.**
I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Client Signature: _____ Date:_____

Practitioner Signature: _____ Date: _____

Patient Information Authorization / Release
Please initial each that apply and then sign and date at the bottom.

____ I authorize the above therapist to release all relevant information from my therapeutic massage sessions to my physician or other healthcare provider(s) or insurance company as requested. Further I give consent to allow the above named therapist to consult with and/or receive similar information from my other healthcare provider(s) or insurance company in order to facilitate my treatment(s).

____ I authorize the release of any medical or other information necessary to process this claim.

____ I authorize payment of medical benefits directly to the therapist. I agree to be responsible for any balance left after insurance payments for any services declined by my insurance company.

Client Signature: _____Date:_____

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