Acupuncture Health Company

Client Intake Form – Therapeutic Massage

Personal Information:

Name ________________________ Phone (Day) ________________________ Phone (Eve)

Address ________________________

City/State/Zip ________________________

email ________________ Date of Birth ________________ Occupation ________________

Emergency Contact ________________________ Phone ________________

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit ________________________

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? ________________________

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain ________________________

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain ________________________

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe ________________________

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe ________________________

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ________________

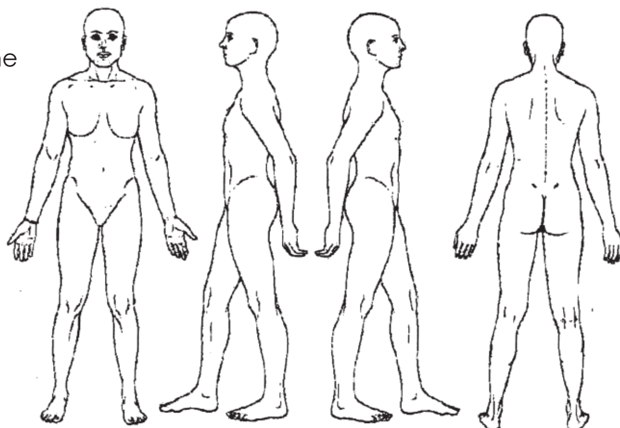
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify ________________________

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain ________________________

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

11. Are you currently under medical supervision? Yes No
    If yes, please explain ______________________________
12. Do you see a chiropractor? Yes No If yes, how often? ______________________________
13. Are you currently taking any medication? Yes No
    If yes, please list ______________________________
14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any condition that you have marked above ______________________________
____
____

Have you ever been on any muscle/tendon compromising antibiotics such as Cipro, Levaquin, Avelox, Floxin or Noroxin?
No_____ Yes_____If yes, when?_____________

Are you on any type of blood thinners (for example: Coumadin (warfarin), Dicumarol (dicumarol), Miradon (anisinidione), Pradaxa (dabigatran)? No______ Yes______

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? ______________________________
____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, ______________________________(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. 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 specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client ______________________________ Date ____________________

Signature of Massage Therapist ______________________________ Date ____________________

Acupuncture Health Company

General Policies

1. We make every effort to keep the cost of care down. To assist this effort, you are expected to pay in full for acupuncture and/or herbs upon completion of each visit. We accept cash or checks. We do not accept credit cards. If payment is not rendered at time of service there will be an additional $30.00 service charge.

2. Returned checks are subject to a $30.00 service charge.

3. All patients are seen on an appointment basis. Please call well in advance so we can reserve a time for you. Please be aware that **AT LEAST 24 HOURS NOTICE OF CANCELLATION** IS REQUIRED TO AVOID A MISSED/LATE/CANCELLED APPOINTMENT CHARGE . If you are unable to give us 24 hours advance notice you will be **charged the full amount of your appointment**. This amount must be paid prior to or at your next scheduled appointment.

It is the patient's responsibility to remember an appointment. Reminder calls or e-mails are made only as a courtesy. Anyone who either forgets or does not show up for their appointment will be considered a "no-show." **"No-shows" will be charged the full amount of their appointment.** This amount must be paid prior to or at your next scheduled appointment.

We strive to provide the highest level of service. Failure to cancel appointments with sufficient notice denies an opportunity for other patients on our waiting list to be seen at the time reserved for you.

4. Please arrive on time to get the full value out of your treatment. If you find that you cannot be on time, please notify our office as soon as possible. If you are late for your appointment, the practitioner may not be able to see you at that time or may not be able to give you the full amount of time originally slotted for you.

5. To insure we can easily contact you, please advise us of any change in your address or phone number(s).

6. We do not accept health insurance or file health insurance claims. However, we will do our best to provide you with the documentation required for you to submit claims to your insurance provider.

8. We will automatically sign you up for our e-mail newsletter. You may opt out of this at any time by e-mailing us.

7. We request that you eat a snack or a small meal two hours prior to receiving your treatment.

By voluntarily signing below, I acknowledge that I have read each of the above statements in detail, understand each line item fully and will be compliant.

Patient Full Name: ____

Patient Signature: ____ Date: ________

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919-960-1054