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: _____

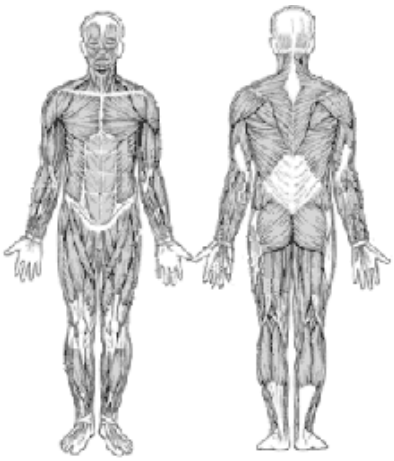
What were the results? _____

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 _____

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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)