NEW CLIENT INTAKE FORM Date: ____________

Name ____Date of Birth________ ____

Address____ ____________________

Telephone H ___________________________ Telephone (O/M)______________________

Best time to call _____________Email ____

Occupation: _________________________Referred by:______________________________

Have you received massage therapy before today? Yes____ No_____ Date of last massage: __________________

What areas would you like to focus on today and/or future sessions? (Circle all that apply)

Stress relief	Reduce pain & stiffness	Relaxation	Reduce muscle tightness
Overall wellness	Sports Conditioning	Increase ROM	Prevention

Other: ____

List the physical activities you enjoy and how often you participate in them.

____

What are your current health and/or fitness goals? ____

____

What is your main activity at work or during the day? (Circle all that apply)

Phone work Sitting Computer Work Standing Walking Bending Other: _______________

Do you experience any discomfort, pain or limited range of motion doing these activities? (Please explain)

____

How many hours a day do you spend at work or school? ____________________________________

Do you make time in your day or week for fun and relaxation? Yes No Working on it

What types of things do you do to manage stress if/ when it presents itself? ______________________

Is there anything else you would like to implement regarding wellness that we have not covered on this form?

____

Medical History Information

Please circle any of the following that apply to your personal health (past or present)

Headaches	Chronic Pain	Varicose Veins	Muscle or Joint Pain
Blood Clots	Sinus problems	Osteoporosis	Numbness/Tingling
Scoliosis	Depression/Chronic Fatigue	High/low blood pressure	TMJ/Jaw Tightness
Arthritis	Sprains/Strains	Diabetes	Cancer/tumors
Neck Pain/Stiffness	Carpal Tunnel	Infectious disease	Stroke
Sciatica	Cardiovascular/Heart Conditions	Insomnia	Low Back Pain
Poor circulation	Kidney issues	Rotator Cuff Injury	Grief
Car accident	Pulmonary disease	Seizures	Parkinson's/MS
Herniated/Bulging Disc	Shingles	Knee Replacement	Hip Replacement

Other: ____

Below list current health care providers (Physician, Chiropractor, Physical Therapist, Other).

Practioner: ____ Phone ____________________

Practioner: ____ Phone____________________

List previous accidents, sports injuries, falls and surgeries (approx. dates).

____

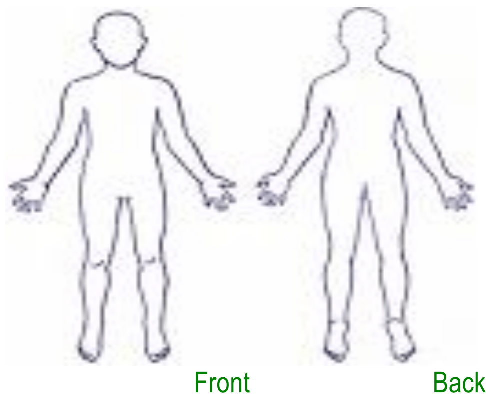
____

List all the medications you are currently taking and what they are for:

____

____

Please place an X on any area causing you current discomfort or are chronic problem areas



Front Back

To the best of my knowledge all the information contained above is accurate. I will agree to keep my therapist updated as heath conditions change. I understand that a massage therapist shall not diagnose a patient's medical condition but evaluate whether the application of massage therapy is advisable. I also understand that a massage therapist may provide treatment, education and evaluation of disorders of the musculature and soft tissue of the human body within their scope of practice.

Signature____ Date______________________

MEDICAL WAIVER & POLICIES FORM:

1. I understand that medical massage is not a substitute of medical examination, diagnosis, or treatment by a physician and nothing said or done in this or following sessions should be construed as such.

2. If I experience any undue pain or discomfort, I will let my therapist know, so she can adjust the technique to meet my needs.

3. Because massage should not be done under certain medical conditions, for the safety and health of the client, I have stated all my known medical conditions honestly and completely.

4. I will give a minimum of 24-hour notice if I need to change or cancel an appointment. I understand this time is set-aside for me and there is no double booking. I understand that payment is due for any scheduled appointment I miss and do not cancel.

5. In the case of a medical or personal emergency I will contact my therapist as soon as possible to avoid being charged for a missed session. I realize this is on a per case basis, and a fee may be charged.

6. Due to the nature of the business I understand that if I arrive late my session will end at its originally scheduled time and payment is due for the full session.

7. In a therapeutic relationship I understand the importance of confidentiality: All clients can expect information obtained in the course of our therapeutic relationship to be kept confidential under HIPPA rules, except with a written consent signed by the client to release information, or if the client discloses information that he/she may be considering harm to themselves or to others.

8. I understand that if I am using a Health Savings Account for Medical Massage that I need to have a physician referral form on file and update it annually.

9. After the massage I understand that toxins are released from the soft tissues during a massage, it is recommended that I drink plenty of water for 24 to 48 hours following my session. If I have any questions or concerns regarding how I feel after my session, I will contact my therapist.

10. By signing below I agree to abide to the above policies:

Signature: ____Date: ______________

Donna L Armentrout, LMT
Dayton Massage Connection, LLC

New Client Office Policies & Medical Waiver

All clients are to complete a New Client Intake form, Medical Waiver & Policy Form prior to receiving a service. This information will help me design your session and provides answers to many questions.

ARRIVALS: Clients are encouraged to arrive at least 10-15 minutes prior to your scheduled appointment, to complete paperwork and allow yourself time to get acquainted with your surroundings.

Due to scheduling and new sanitation requirements I am unable to make up for lost time due to a late arrival, so your session will end at its originally scheduled time. Please plan accordingly.

LENGTH OF SESSIONS: Standard hands-on sessions for therapeutic, medical or sport massage are 50 minutes in length. On certain occasions the length of a session will vary. Chair massage Bodywork & Personal Training sessions can range between 15 – 45 minutes in length. Duration varies depending on the nature of the problem(s) and your individual goals. These will be determined during the initial booking or intake session.

PAYMENTS: Payment is due at the time of service via cash, Venmo @Donna-Armentrout, check, or credit card.

I understand that if I am using a Health Savings Account for Medical Massage that I need to have a physician referral form on file prior to my session and update it annually.

CANCELLATIONS/NO-SHOW POLICY: I will give a minimum of 24-hour notice if I need to change or cancel an appointment. I understand this time is set-aside for me and there is no double booking. I understand that payment is due for any scheduled appointment I miss and do not cancel.

As a courtesy to others please call ahead, so that I may offer your appointment time to others.

Gift Certificates and Pre-Paid Packages:

If a gift certificate is being used as form of payment for a missed appointment that gift certificate will no longer be valid. In the event that you have purchased a package of sessions, one appointment will be deducted from your remaining appointments to cover the missed one.

CONFIDENTIALITY: All clients can expect information obtained in the course of our therapeutic relationship to be kept confidential under HIPPA rules, except with a written consent signed by the client to release information, or if the client discloses information that he/she may be considering harm to themselves or to others.

Donna L Armentrout, LMT

Dayton Massage Connection, LLC

Medical Wavier

1. I understand that medical massage is not a substitute for medical examination, diagnosis, or treatment by a physician and nothing said or done in this or following session should be construed as such.

2. If I experience any undue pain or discomfort in this or following sessions, I will let the therapist know, so she can adjust the technique to address my comfort level.

3. Because massage should not be done under certain medical conditions, for the safety and health of the client, I have stated all my known medical conditions honestly and completely.

4. Due to the recent recommendations from the CDC regarding the Coronavirus I understand that my therapist will be wearing a mask and gloves for my safety. I will be required to wear a mask while on my back but I am not required to wear one while lying on my stomach for ease of breathing.

5. I understand that if I have a cold, dry cough, shortness of breath, fever or feel like I am coming down with an illness I will reschedule my appointment.

6. Due to the recent spread of the Coronavirus and contact tracing I give my therapist permission to share my name and contact information listed below with a client who has contracted the virus or health department for health & safety reasons.

7. All clients can expect information obtained in the course of our therapeutic relationship to be kept confidential under HIPPA rules, except with a written consent signed by the client to release information, or if the client discloses information that he/she may be considering harm to themselves or to others.

By signing below, I agree to the above policies:

Signature: ______________________________________ Date: _________________________

Email: ____. Phone: ________________________