**MASSAGE THERAPY INTAKE FORM** Date: _____

Name _____ Date of Birth _____

Address _____

Telephone H _____ Telephone (O/M) _____

Best time to _____Email _____

Occupation _____Referred by:_____

Have you received massage therapy before today? Yes_____No _____ Frequency _____ last massage: _____

Reason _____

List physical activities you participate in regularly. _____

What movements or activities are limited? _____

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

_____

List previous major injuries/surgeries (approx. dates).

_____

What other treatments are you receiving and by whom (Acupuncture, PT, OT, MD, DC): _____

Practioner:_____ Location/Phone_____

Practioner:_____ Location/Phone_____

List medications and supplements: _____

_____

What seems to help the most? _____

What seems to aggravate the condition the most? _____

What is your main activity at work? ☐ On Phone ☐ Sitting ☐ Computer Work ☐ Standing ☐ Walking ☐ Bending ☐ Other

_____

_____

## Medical History Information

Please check 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 | ☐ Jaw Pain/Teeth Grinding | ☐ Fatigue | ☐ Numbness/Tingling | ☐ Scoliosis |
| ☐ Depression | ☐ High/low blood pressure | ☐ Arthritis | ☐ Sprains/Strains | ☐ Diabetes |
| ☐ Cancer/tumors | ☐ Neck Pain/Stiffness | ☐ Carpal Tunnel | ☐ Joint Replacement | ☐ Stroke |
| ☐ Sciatica | ☐ Heart Condition | ☐ Insomnia | ☐ Low Back Pain | ☐ Poor circulation |
| ☐ Kidney infection | ☐ Limited Range of motion | ☐ Osteoporosis | ☐ Rotator Cuff Injury | ☐ Seizures |
| ☐ Car accident | ☐ Sports Injury | ☐ Grief | ☐ Shingles | ☐ Parkinson's/MS |

Other _____

_____

_____

What do you do to relieve stress? _____

Do you have any health or fitness goals this year? _____

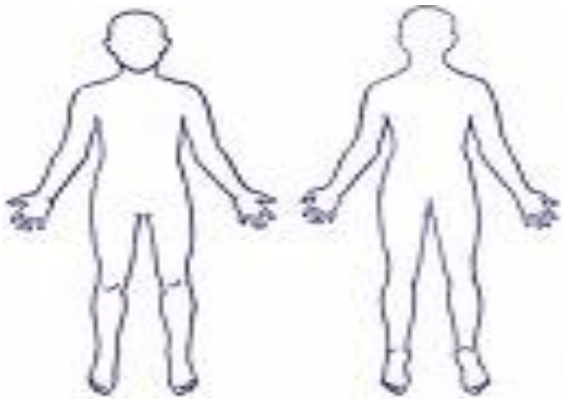
_____

What do you want to get out of your session (s)? Check all that apply.

| | | | | |
|---|---|---|---|---|
| ☐ Stress relief | ☐ Reduce pain & stiffness | ☐ Relaxation | ☐ Injury | ☐ Self-care |
| ☐ Overall wellness | ☐ Reduce muscle tightness | ☐ Sports Conditioning | ☐ Increase ROM | ☐ Prevention |

Other: _____

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



Front Back

To the best of my knowledge the medical 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_____

**Dayton Massage Connection, LLC**
**Donna L Armentrout, LMT**

## 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.

**ARRIVALS**: Clients are encouraged to arrive at least 5-10 minutes prior to your scheduled appointment, to allow yourself time to get acquainted with your surroundings.

Due to scheduling I am unable to make up for lost time due to a late arrival your session will end at its originally scheduled time. So please plan accordingly. Initial _____

**LENGTH OF SESSIONS**: Regular sessions for therapeutic, medical or sport massage are 50 minutes in length. After the initial intake session and goals are reviewed shorter or longer sessions are available for muscle specific work or conditions requiring extra time. Initial _____

**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.* Initial _____

**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. Initial _____

**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. Initial _____

**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. Initial _____

**Dayton Massage Connection, LLC**
**Donna L Armentrout, LMT**

**MEDICAL WAIVER**

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 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. 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.

5. 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.

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

7. By signing my name below, I agree to abide to the above policies:

Signature: _____ Date: _____