# MASSAGE THERAPY INTAKE

**✳ Please arrive 5 min. prior to scheduled appointment time to take your photo and input paperwork.**
**Remember to bring completed paperwork. (If paperwork not completed, arrive 15 min prior to appt.)**

First Name: __________________________ MI: _________ Last Name: ________________________ SS# ___________________

Street Address: __________________________________ City: ________________ State: _________ Zip: ___________________

Home Phone: ________________________ Cell: ________________________ Email: ____________________________________

Sex: ☐ M ☐ F DOB: ___/___/_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: __________________________ Work Address: _________________________________________ Zip: _____________

Occupation: ___________________________________________________ Work Phone: _________________________________

Emergency Contact Name: __________________________ Phone: __________________________ Relationship: _______________

Do you give permission for Dr. Davies to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: ____________________________ Who may we thank for referring you to us? ___________________

## INSURANCE INFORMATION

**Insurance Companies often cover massage/manual therapy.** We would be happy to call your insurance company and see if these services are covered? Please fill out your insurance information and we will contact you.

Insurance Company: ___________________________________ Insurance Company's phone number: _______________________

ID or Policy Number: ___________________________________ Group Number: _________________________________________

## PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Health Insurance ☐ Cash

☐ This injury is related to a Work Injury. Date of Injury: ___/___/____.

☐ This injury is related to an auto accident. Date of Accident: ___/___/____.

## ASSIGNMENT AND RELEASE

Scheduling an appointment reserves that time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment**. **If 24 hours is not given, a charge of $20** will be billed to your account.

I ___________________________________ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment**. I agree to allow Dr. Mark Davies, DC, CCN, CCSP, RN to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize payments to be made directly to Dr. Mark Davies, DC, CCN, CCSP, RN for treatment rendered. **I understand that co-payments and cash fees are due at the time of service and that I may receive an additional bill for services not covered by my insurance.**

**Patient's Signature:** ________________________________________________ **Date:** ________________________________

Parent or Guardian's Signature if under 18

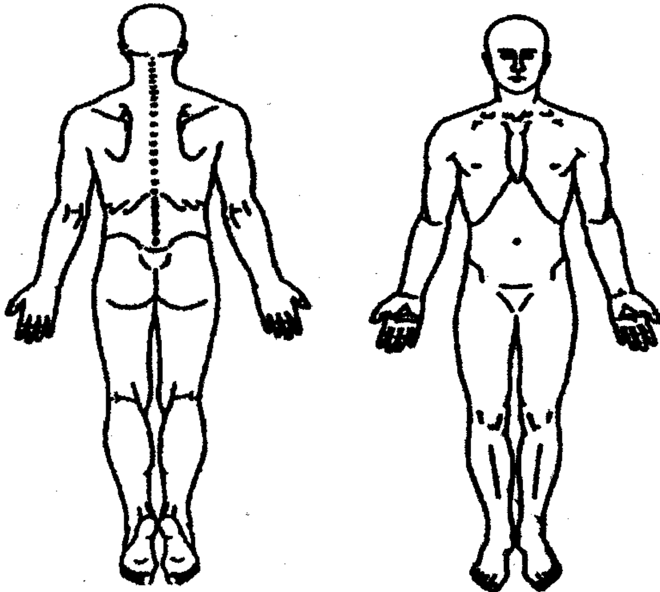
For office use only: ☐ Photo ☐ Copy Ins Card ☐ Intake Complete

# Massage Therapy Goal Form

1. What is your **goal** with massage therapy? ____________________________________________
2. Is there any symptom/condition you specifically want massage therapy for? ______________________

**Using the following abbreviations to indicate where you are experiencing symptoms**

**P** = Pain  **S** = Stiffness  **A** = Aching  **B** = Burning  **NT** = Numbness / Tingling



3. When did your symptoms **begin**?

   ______________________________________

4. Did the symptoms begin **gradually** or **suddenly**? ____________________________
5. Was there any **trauma** involved? **YES NO**

   If yes, describe:__________________________

   ______________________________________

   ______________________________________

6. Any **changes** in the following? **YES NO**

   If yes, check & describe:

- ❑ Work duties
- ❑ Hobbies
- ❑ Exercise (new or changed)
- ❑ Eating habits
- ❑ Ergonomics
- ❑ Lifestyle
- ❑ Stress
- ❑ Sleep patterns

7. Are the symptoms **constant** or tend to **come and go**? ______________________________________
8. How **often** do the symptoms bother you? _____________________________________________
9. How **long** do the symptoms last for? _________________________________________________
10. Do you have **pain at night**? **YES NO** Is the condition getting **progressively worse**? **YES NO**
11. Has this condition **bothered you before**? ______________________________________________
12. Would you **describe** it as (circle): SHARP, SHOOTING, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBING, NUMBNESS, TINGLING, CRAMPY, OTHER:____________________________
13. Does this condition **prevent** you from any **daily** or **recreational activities**? **YES NO**

    If yes, please describe: ______________________________________________________

14. What **aggravates** the condition? ____________________________________________________
15. What **relieves** it?___________________________________________________________
16. Are there any **other symptoms** that you can associate with this condition? **YES NO**

    If yes, please describe: ______________________________________________________

17. If not mentioned above, do you ever experience **foot** or **knee pain**? **YES NO**

18. Have **you** or **anyone** in your immediate **family** suffered from (circle):

- Cancer
- Arthritis
- Aneurysm
- Stroke
- Skin condition
- Heart disease
- High blood pressure
- Osteoporosis
- Diabetes
- Depression
- Neck pain
- Back pain
- Knee pain
- Foot pain
- Other: _______________

19. Have you ever had any **serious illnesses**? _______ Describe:_______________________________

20. Have you ever had **surgery**? _______ Describe:__________________________________________

21. Have you ever been **hospitalized**? ________ Describe:____________________________________

22. Any **major trauma's**? (i.e. Falls, Car accidents, Work related injuries, Fractures?)_____________

_____________________________________________________________________________________

23. Are you taking any **medications** or **contraceptives**? _____________________________________

24. Are you taking any **vitamins** or **herbs**? ________________________________________________

25. Do you have any **allergies**? _________________________________________________________

26. Have you ever had spinal **X-rays, MRI or CT** scan? ______________________________________

27. When was your **last Physical exam**? ____________ Outcome / concerns? ___________________

28. Do you **smoke**? _______ cig/day______

29. Which of the following do you do at **work**:

- Sit
- Stand
- Heavy lifting
- Prolonged postures
- Repetitive motions
- Other:_____________ ___

30. What **form** of **exercise** you do on a weekly basis?

- Weights
- Aerobics
- Jogging / walking
- Swimming
- Biking
- Other:______________ _

31. How many hours do you **sleep** at night? ________ Do you feel **rested** in the morning? Yes / no

Signature of Patient: _________________________________________________ Date: _________________________

Parent or Guardian: ___________________________________________________ Date: _________________________

(If patient is under 18)

# MUTUAL UNDERSTANDING & CONSENT TO TREATMENT
## For Massage Therapy

**Name: _____________________________________________ Date: _____________________________**

The following information is provided to enable our sharing of common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during massage therapy sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.

- All procedures and/or treatment carries with it both risk and benefits. Massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer positive experience of touch.

- The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. Massage therapy is not a substitute for care by a physician. It is recommended you concurrently continue to work with your doctor. Massage therapists are not trained to diagnose illness or disease, do not prescribe medication and spinal manipulation is not part of massage therapy sessions.

- There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s).

- Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.

- You are responsible for payment of treatment regardless of insurance coverage. As a courtesy, we provide insurance billing service. However, each insurance plan offers different levels of reimbursement and/or coverage for services. Many “preventative approaches” to healthcare are not covered by insurance plans. At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier. Our office does not bill or affiliate with Medicare/Medicaid, and Medicare/Medicaid.

- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments by other providers between visits.

- You are encouraged to ask questions on ay health-related topic and to take an active role in your health care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyles that can help you attain your highest level of health.

My signature below assures that the contact information, health history, and other information that I provide on my intake forms are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

Signature of Patient: ___________________________________________________ Date: ___________________________

Parent or Guardian: _____________________________________________________ Date: ___________________________

(If patient is under 18)