Client Intake Form – Therapeutic Massage

Confidentiality: Please note that all information given on this form or during a session is strictly confidential and will never be released without your written permission.

Personal Information

Name:	DOB: / /	Sex (circle): Male Female
Social Security *(This information **must** be provided for insurance billing)*:		
Address:	City:	State/Zip:
Home Phone:	Cell Phone:	Email:
Marital Status (circle): S M D W	Employment Status: Employed Student Retired Other_____	
Emergency Contact:	Relationship:	Phone:
Primary Health Care Provider:	Phone:	City/State:

Employment Information

Employer:	Occupation:	Work Phone:
Address:	City:	State/Zip:

Responsible Person (if minor child) or Primary Insurance Policy Holder (if insurance claim)

Name:	DOB: / /	Sex (circle): Male Female
Social Security *(This information **must** be provided for insurance billing)*:		
Address:	City:	State/Zip:
Home Phone:	Cell Phone:	Relationship:

Are you seeking treatment due to a new or previous (circle): On-the-job Injury Auto Accident

Date of accident:_____/_____/_____
Insurance Co. Name_____ Claim/Policy #: _____
Name of Claims Manager/Adjuster_____ Phone: _____
Address: _____City:_____State/Zip:_____
Name of Attorney: _____ Phone:_____

How did you hear about us?
Name/source of referral:

The following information will be used to help plan safe and effective massage sessions. Please answer to the best of your knowledge. If more room is needed for any question(s), please use back of sheet.

Medical Information

Are you currently under medical supervision? Yes No
If yes, please explain _____
_____

Are you currently taking any medication? Yes No
If yes, please list medication(s) and condition(s) being treated_____
_____
_____

Are you currently pregnant? Yes No
If yes, number of weeks? _____
Any high risk factors? _____

Have you had any orthopedic injuries, surgeries, and/or replacements? Yes No
If yes, please explain _____
_____
_____

Do you suffer from chronic pain? Yes No
If yes, please explain _____
_____
What makes it better? _____
_____
What makes it worse? _____
_____

Please indicate any of the following that apply to you currently or previously.

☐Cancer
☐Diabetes
☐heart attack/stroke
☐Epilepsy
☐Tendonitis/Bursitis
☐TMJ
☐Fibromyalgia
☐bruise easily
☐DVT/blood clots
☐Herpes/cold sores
☐sprains/strains
☐recent fracture
☐decreased sensation
☐varicose veins
☐numbness/tingling
☐Shingles
☐athlete's foot
☐current fever
☐chronic fatigue
☐high/low blood pressure
☐headaches/migraines
☐allergies/sensitivities
☐Arthritis/Gout
☐Asthma
☐Lupus
☐neuropathy
☐open sores or wounds
☐osteoporosis
☐skin condition(s)
☐heart condition
☐recent surgery
☐circulatory issues
☐back/neck problems
☐contagious skin condition(s)
☐MRSA
☐acne
☐current swollen glands
☐recent exposure to ringworm, scabies, bedbugs, or lice
☐Any condition not listed above:
_____
_____

Massage Information

Have you had professional massage before? Yes No
If yes, how often do you receive massage therapy? __
_____

What type of massage are you seeking?
☐Relaxation/Swedish ☐Therapeutic/Deep Tissue
☐Other:_____

What type of pressure do you prefer?
☐Light ☐Medium ☐Deep

Are you sensitive to touch or pressure, or ticklish in any area: Yes No
Where at?_____

Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain_____
_____

Do you have any allergies/sensitivities to oils, lotions, ointments, essential oils, scents, or nuts? Yes No
If yes, please explain_____
_____

Do you have sensitive skin? Yes No

Are you wearing any of the following?
☐contact lenses ☐dentures ☐hearing aid(s)
☐ hairpiece/hair extensions

Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please explain_____
_____
_____

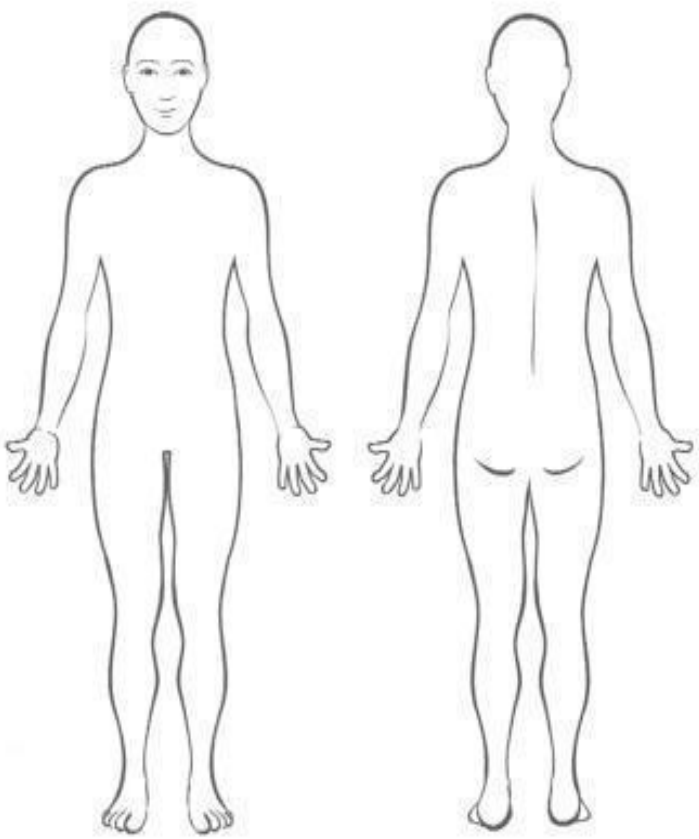
Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe_____
_____
_____

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
☐depression ☐other_____

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

If yes, please describe_____
_____
_____

Mark any areas where you are experiencing discomfort.



On a scale of 1-10, with 1 being minimal and 10 being excruciating, what is your current level of discomfort/pain? _____

Approximately what percentage of the day, 0-100, are you experiencing pain? _____%

Circle areas of your life being affected by, limited by, or you are unable to perform due to pain.

Household chores (vacuuming/dishes/laundry, yardwork, etc.)

Driving

Working

Sleeping

Bending

Sitting

Standing

Turning

Exercising

Taking care of children/family members

Lifting

Pulling

Reaching

Personal activities (dressing/showering, etc.)

For Auto accidents please circle one. Since the accident my pain has been…

Better Same Worse

Circle any of the following areas you **DO NOT** want massaged:

head face chest
stomach buttocks hands feet
other:_____

Life Reset Healing Arts Puyallup, WA (910) 616-1752 https://LifeResetHealingArts.com

Client Agreement & Consent Form

Please read carefully, initial in the yellow boxes, and sign in the appropriate places.

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 a session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. _____

I acknowledge that massage is not a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists do not perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness, and that nothing said in the course of the session 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 of 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. _____

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 understand that massage therapy is non-sexual and that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session and **I will be required to pay the full amount** for the scheduled appointment. I also understand that I will be barred from any future services. _____

I understand that written consent must be provided by a parent or legal guardian for clients under the age of 17 and that they must be accompanied by a parent or legal guardian during the entire session. _____

I understand that **massage is contraindicated** for individuals who are **under the influence of alcohol, recreational drugs (including marijuana), and prescribed narcotics.** Life Reset Healing Arts has a **zero tolerance** policy. ***I understand that being under the influence will result in immediate cancellation of the session and that I will be required to pay the full amount due for the scheduled appointment.*** _____

I agree that if I am running late for a scheduled appointment, I will make every effort to let my therapist know beforehand by phone or text message. I understand that if I arrive late, my session will end at the originally scheduled time and that the full amount will be due for the scheduled session. _____

I understand that **24 hour notice is required to cancel or reschedule any appointment** and **that less than 24 hour notice will result in a charge of 100% of the scheduled service(s)**. I understand that if I **No-Show** an appointment I **will be charged 100% of the scheduled service(s)**. _____

Signature *(or signature of parent or legal guardian, if minor client)* **Date**

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Financial Policies & Insurance Agreement

Check the box next to all policies you wish to use, *including "cash" (in the event this is used at a later date)*. Be sure to read carefully and make sure you understand and agree prior to signing this document. Initial all yellow boxes and sign in the appropriate places.

*Please note: If you are using any of the following policies for payment of services, with the exception of cash, **you MUST have a referral or prescription for massage therapy from your physician, or other health care provider. NO EXCEPTIONS!** Your referral must include a start date and diagnosis codes. By law, Massage Therapists are not allowed to diagnose you, and diagnosis codes are required for billing purposes.

[ ] **CASH PATIENT**: Payment is required at time of service. We accept cash, checks, and credit cards. *(Any returned check with result in a $75 NSF fee and all future appointments with require cash or credit card.)* I certify that I am a cash client and responsible for all fees for service.

[ ] **HEALTH INSURANCE**: Every insurance policy is different and it is up to you to know beforehand exactly what your benefits are and what the requirements are for having your claims accepted. We will gladly submit medical claims to your insurance company, but there is no guarantee your policy will cover and pay for massage therapy. **You are liable for claims rejected by your insurance company and any amounts not paid**. Copayments, percentages, and deductibles are due at the time of service. Accounts over 30 days will be subject to a $50 billing fee and/or interest charges of 12.5%. Accounts over 90 days will be charged a $250 collection fee and sent to Physicians & Dentists Collection Agency. You will be responsible for all legal fees.)

[ ] **PERSONAL INJURY PROTECTION (PIP)**: If you were involved in a motor vehicle accident, your auto insurance policy may pay for your treatment. Your treating physician(s) must authorize treatment and provide a written referral. If your personal injury policy does not cover your treatment, your policy limits are exhausted, or your carrier has suspended benefits, your claim will revert to a Third Party Claim or No Insurance/Cash Payment status.

[ ] **THIRD PARTY CLAIMS**: In the event you do not have Personal Injury Protection under your auto insurance policy, arrangements can be made to hold your bill until the time of settlement with the third party carrier. In order to receive treatment under a third party claim, your treating physician(s) must authorize treatment and provide a written referral. You must sign a third party attorney's lien and have obtained legal representation from an attorney who will sign the lien. An auditor's lien may be filed against your claim with the Pierce County Auditor.

I, _____, certify that I have insurance coverage as listed above and assign all insurance benefit payments directly to Life Reset Healing Arts. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Life Reset Healing Arts to release all information necessary, including medical records, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature *(or signature of parent or legal guardian, if minor client)* **Date**

_____ _____

I, _____(print name) consent to therapeutic massage treatment. I attest that the health information I have provided is true and complete to the best of my knowledge. I understand that the information I have provided is confidential and will not be released without my written consent. _____

I agree to pay all charges for health care services received. I understand that having a health/auto/L&I insurance policy or claim is not a guarantee of coverage. I understand that I am financially responsible for any amount not paid and any claim/amount rejected by my insurance company. _____

I understand that **copays/deductibles are due at the time of service** and that returned checks and balances older than 30 days are subject to additional fees, interest, and billing charges. _____

I understand that **any balance over 90 days will be charged a $250 collection fee and be turned over to Physicians & Dentists Collection Agency**. I further understand that I will be responsible for all legal fees incurred. _____

Signature *(or signature of parent or legal guardian, if minor client)* **Date**

Hot Stone Massage Release Form

We may or may not use this** modality during your visit(s), buts require a copy of the release form for your file. **If there is a contraindication listed that applies to you, or for any reason you do not wish to utilize these treatments, simply "X" out the release form.

Hot Stone Massage Contraindications

Hot stone massage is not suitable for everyone. There are risks associated with performing hot stone massage on individuals with the following conditions.

You must inform your massage therapist/practitioner if you have any of the following conditions which may make hot stone massage contraindicated or may require your therapist/practitioner to alter the massage.

- ☐ Pregnancy
- ☐ Diabetes
- ☐ Inflammatory skin conditions
- ☐ Open wounds or sores
- ☐ Hypotension or Hypertension
- ☐ Cancer (with or without treatment)
- ☐ Varicose veins
- ☐ Under the influence of drugs or alcohol
- ☐ Blood clot(s)
- ☐ Neuropathy
- ☐ Autoimmune condition (MS, Lupus, RA, etc.)
- ☐ Peripheral vascular disease
- ☐ Heat sensitivity
- ☐ Compromised immune system
- ☐ Edema or Lymphedema
- ☐ Cardiovascular disease

Client's Release

Please check the following that applies to you.

☐ I, _____, have read and understand the aforementioned conditions which make hot stone massage contraindicated and have disclosed any and all health risk factors. I understand the information contained on this form and confirm that I **DO NOT** have any of the above conditions. I hereby give my full consent to receive hot stone massage and take full responsibility of any side effects or harm that may come from my receiving hot stone massage. I understand that I will be receiving hot stone massage as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I release the massage therapist/practitioner of any and all liability for any harm that may unintentionally occur during my treatment(s).

☐ My condition(s) **IS/ARE** listed above and therefore ***make(s) hot stone massage contraindicated***.

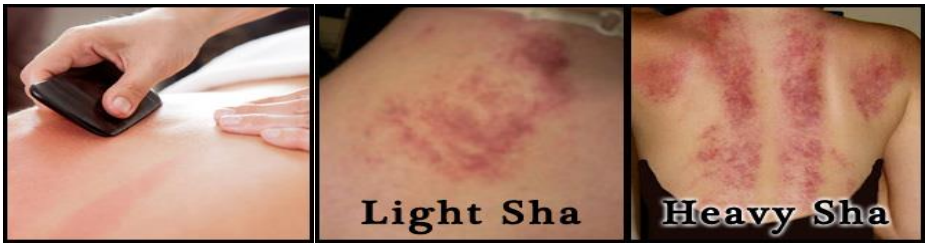
Signature _____Date _____

The following is information for you to ***read and keep*** *regarding Gua Sha & Cupping.* ***We may or may not use these*** *modalities during your visit, but we require a release form for your file.* ***If there is a contraindication listed that applies to you, or for any reason you do not wish to utilize these treatments, simply "X" out the release form.)***

Gua Sha

What is Gua Sha

Gua Sha is a traditional Chinese medicine technique where the skin is scraped with a smooth instrument in order to help relieve congestion, move metabolic wastes out of the tissues, and increase blood flow. Repeated scraping over an area brings stagnant blood and lymph up to the surface of the skin, which allows the body to metabolize and remove accumulated cellular wastes quickly, promoting fresh blood and new cells to the area. This scraping results in the appearance of tiny spots on the skin, called petechiae (*sha*), which typically fade in 2 to 3 days, but can last for up to 2 weeks.



Although the sha marks can appear to be, they are **not bruises**. Gua Sha does not traumatize or injure the tissues and is not at all painful when performed correctly. Greenish black or dark purple sha indicates stagnation and toxicity being released. Brown sha indicates that fluids are deficient in the body. Red sha indicates excess heat is being released.

Gua Sha is commonly used as a treatment for neck, shoulder, and back pain, fever, colds and coughs, and muscular pain. In most cases, relief is felt in the areas being worked on almost immediately. It's as if the area can breathe again, opening up and feeling free once more.

Contraindications:

- Broken skin/wounds
- Sunburns
- Bruises
- Skin disruptions that may bleed
- Boils/pimples, skin tags
- lesions on the skin
- Infection
- Bleeding disorders
- Anticoagulant medications
- Recent fracture
- Recent surgery
- Varicose veins/phlebitis
- Pregnancy
- Weak or inflamed patients

What you can expect after treatment

After a Gua Sha treatment, many people experience sweating. This is normal and is the body's way of releasing toxins that have been locked inside. Be sure to rest and have plenty of room temperature water. *(Cold water is destructive to internal organs, so no ice!)* It's also very common to have emotional releases. Take time for yourself. Eat clean and fresh foods. You may find yourself being sensitive to activities, too many people, and loud noises. You may also want to sleep more than usual. These things are all normal and should be welcomed

~ they indicate that healing is taking place. Let the body rest and relax into the healing process. Within a day or two symptoms begin to fade and you may find yourself feeling happier, more alive, and generally healthier.

Aftercare

Because Gua Sha opens the tissues to facilitate the release of heat, wind, or toxins, areas worked on should be considered vulnerable to "invasion" by wind, wetness, cold, and heat. Make sure to keep areas covered and away from coldness or wind for several days. No baths, hot tubs, saunas, etc. for 24 hours following treatment. If possible, do not to shower for at least 12 hours. If this is not possible, use only lukewarm water and very mild soap. Do not exfoliate or shave areas for 24 hours.

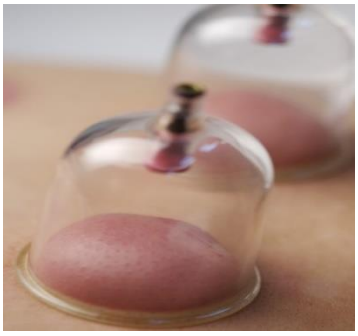
Most important: Water…Water…Water… Rest!

Cupping

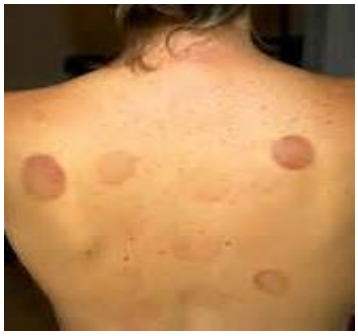
What is Cupping?

Cupping, considered the "sister" treatment to Gua Sha, is a traditional Chinese medicine technique in which a cup is placed on the skin and a vacuum is created inside the cup to lift the tissues, separating the layers and breaking up adhesions that are blocking the flow of qi *(life force energy),* blood, lymph, and nutrients. Cupping can be used to effectively treat muscle aches and pains, stress, myofascial restrictions, and much more. The cups are either left in place for the whole treatment, or glided around the skin to treat a broader area. Any circular or striped markings left on the skin are painless and will typically disappear within a few days to around a week.

One benefit of cupping is that the pulling action engages the parasympathetic nervous system, allowing a deep relaxation to move through the entire body. It is not unusual to fall asleep when receiving this treatment. Many times people are surprised by how relaxed they feel during and after. There is a feeling of ease and lightness that can last for days following a treatment.



Similar to Gua Sha, there may be circular or striped markings left on the skin after treatment. These are painless and will typically disappear within a few days to around a week.



Contraindications:

- Hernias (current and previous areas)
- Slipped disc
- Pregnancy
- Cancer (must have Dr. approval)
- Weak, ulcerated or broken skin
- Varicose Veins
- Renal failure
- Cirrhosis
- Heart disease
- Uncontrolled High Blood Pressure
- Diabetes
- Energy Depleted Clients
- Clients on anti-coagulants

What you can expect after treatment/Aftercare

See Gua Sha sections above

Cupping/Gua Sha Therapy Client Release Form

We may or may not use this *modality during your visit(s), buts require a copy of the release form for your file.* ***If there is a contraindication listed that applies to you, or for any reason you do not wish to utilize these treatments, simply "X" out the release form.***

Cupping/Gua Sha Contraindications

Cupping and Gua Sha is not suitable for everyone. You MUST inform your massage therapist/practitioner if you have any of the following conditions which are contraindicated.

Broken skin/wounds
Sunburns
Bruises
Skin disruptions that may bleed
Boils/pimples, skin tags
Lesions on the skin
Infection
Bleeding disorders
Uncontrolled high blood pressure
Anticoagulant medications
Recent fracture
Recent surgery
Varicose veins/phlebitis
Pregnancy
Hernias (current or previous areas)
Slipped disc
Weak, thin, ulcerated or broken skin
Renal failure
Cirrhosis
Heart disease
Diabetes
Weak/inflamed/energy depleted patients

Client's Release

Please check the following that applies to you.

☐ My condition(s) **IS/ARE** listed above and therefore ***make(s)*** cupping/Gua Sha ***contraindicated***.

☐ I, _____, have read and understand the aforementioned conditions which make cupping/Gua Sha contraindicated and have disclosed any and all health risk factors. I understand the information contained on this form and confirm that I **DO NOT** have any of the above conditions. I hereby give my full consent to receive cupping/Gua Sha and take full responsibility of any side effects or harm that may come from my receiving cupping/Gua Sha. I understand that I will be receiving cupping/Gua Sha as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I release the massage therapist/practitioner of any and all liability for any harm that may unintentionally occur during my treatment(s).

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping/Gua Sha techniques. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping/Gua Sha Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
- It has been explained to me that there is the possibility of skin discoloration that can occur and that this reaction is not bruising, but cellular debris, pathogenic factors and toxins being drawn to the surface to be

cleared away by my circulatory systems. I further understand that the discolorations will dissipate from a few hours to as long as two weeks, in some cases, and in relation to my after-care activities

- I understand that receiving Cupping/Gua Sha Therapy should not be combined with aggressive exfoliation, done within 4 hours of shaving, after a sunburn or when I'm hungry or thirsty.
- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such situations.
- I understand that because Cupping/Gua Sha therapies are detoxifying in nature, I should avoid excess caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean/purified room temperature water. *(Ice water is very disruptive to your internal system.*)

I, _____ (print name), agree that I have read and understand the above information, will follow the instructions/suggestions stated above. I release the massage therapist/practitioner from any liability or harm.

Signature of Client _____ Date_____

Life Reset Healing Arts Contact Consent

May we contact you at the following?

	Circle Preference	
Home Phone	Yes	No
Work Phone	Yes	No
Cell Phone	Yes	No

May we contact you in the following ways?

	Circle Preference	
Voice Message	Yes	No
Text Message	Yes	No
Email	Yes	No

I understand that I may receive various communications regarding appointments, specials, announcements, etc. I understand that I may change my preferences at any time.

Signature _____ Date _____

We strive to keep communications necessary, pertinent, and valuable to you as a client. If for any reason you ever feel you are receiving too many notices from us, please let us know! We will never SPAM you.