Discover Balance

TREATMENT Massage Intake Form

CONFIDENTIAL INFORMATION
***Please Complete as detailed as possible and bring to your first appointment.**

Name: **Date of Birth:** **Todays Date:**

Address:

Phone:

Occupation/Job functions:

Mark: ___*****Billing/Insurance **OR** ___Pay *at Time of Service* Discounted:

***Records Release & Assignment of Insurance Benefits**

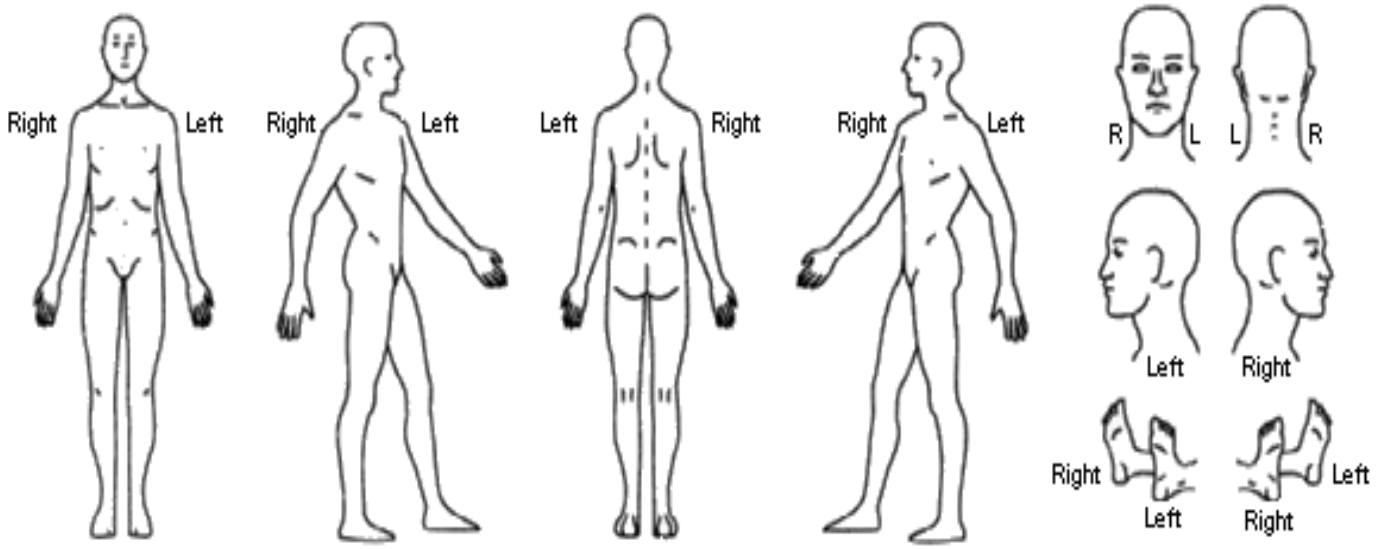
The undersigned hereby authorizes the Release of Information relating to claims for benefits submitted. I agree and acknowledge that I authorize my practitioner to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I (**Patient Name**)_____ hereby authorize (Insurance Co.) to pay and hereby assign *directly* to Evergreen Behavioral Health all owed benefits. I understand I am financially responsible for all charges incurred.

Signed: **Date**:

Reason for visit:

Mark: Have you ever received massage therapy? __Y/__N Type(s)? __ Deep tissue Swedish __Lymphatic __Thai __Shiatsu __Reiki __Cranio-sacral __Fascial Release/Rolphing __Other:_____

Indicate with an **X** area(s) of discomfort on figures below:



Specify if necessary:

Mark: Allergies pertaining to Massage: __ Fragrances/*Scents* __ *Oils* __ *Lotions* __ *Laundry* __ *Materials*(*cotton/latex/etc*)

***Mark*:** Are you currently taking any medications or under the influence of any drugs that may affect or be affected by massage? __Y/__N

Medications: Purpose:

Mark: Are you currently seeing a healthcare professional? __Y/__N

Name: Reasons:

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Please review this list of conditions that have affected your health either currently or in the past. Mark a **C** next to **Current** OR **P** next to the **Past** condition. (Note length of time with symptoms)	
__ Arthritis __ Diabetes __ Blood clots __ Bruise easily __ Cancer __ Chronic pain __ IBS/Constipation/diarrhea __ Auto-Immune Dysfunction (AIDS fibromyalgia, Chronic fatigue, lupus, etc. Specify:_____ __ Hepatitis (A, B, C, other) __ Skin conditions __ Stroke	__ Depression, Anxiety, Other Psych __ Headaches/Migraines __ Heart conditions __ Back problems __ High blood pressure __ Insomnia __ Pregnancy __ Scoliosis __ Seizures __ Chemical dependency (alcohol, drugs) __ TMJ disorder __ Other: _____

Other Specific Significant Variables (**DETAILED AS POSSIBLE**, dating even back to childhood) ***Mark an X Below, then specify***:
__ Motor Vehicle Accidents Dates/Years Ago:
__ Concussions or Loss of Consciousness: Age/Years Ago:
__ Broken Bones Muscle Strains: Age/Years Ago:
__ Significant Falls: Age/Years Ago:
__ Any other traumatic events that may have impacted your health:
__ Hospitalizations/Surgeries: *Date, Reason/Type of surgery, Did it help?* ___Y/__N

Please read the following information and **sign and date** below:

1. I understand that often times it is customary and/or necessary for the LMP to work in regions of the body not ordinarily touched in order to fulfill a therapeutic intent; areas including but not limited to: glutes (butt) pecs (breast) adductors (inner thigh) coccyx (tailbone/butt crack), psoas (stomach/groin).**I understand I have a right to refuse such therapies and will communicate to my provider if; a.I need further explanation *and/or* b. I do not wish for any of these area(s) to be worked on.**

2. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

3. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

4. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date:_____

PLEASE NOTE: *The following sometimes occurs during massage. They are NORMAL responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling/movement of intestinal gas, emotional feelings and/or expression, energetic shifts, memories, falling asleep/tiredness, twitches, etc.*

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