



NEW MESSAGE CLIENT MEDICAL HISTORY AND HEALTH INTAKE

Date _____

Name _____

Address _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

Birthdate _____

Single/Married/Divorced

(circle one)

Occupation _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient _____

Insurance Company _____ Subscriber's Name _____ Birthdate _____ SSN# _____

Group# _____ Subscriber ID# _____

Is patient covered under additional insurance Y/N If yes - please attach copy of medical card.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Karen Burley, LMP and/or Dena Rodland, LMP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practitioner to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

Please check all that apply. If you answer yes to any of the following questions, please explain below.

	YES	NO		YES	NO
Do you frequently suffer from stress?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any broken bones in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have tension or soreness in a specific area?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have cardiac or circulatory problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from back pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have numbness or stabbing pain?	<input type="checkbox"/>	<input type="checkbox"/>
Are you epileptic	<input type="checkbox"/>	<input type="checkbox"/>	Are you sensitive to touch/pressure in any area?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any recent surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical condition I should be aware of?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain here:

Please list all prescribed and OTC medications, supplements, herbs and vitamins you are currently taking.

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage therapy may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session and any future session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, naturopath, or chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. Because massage therapy is contraindicated 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 practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

Patient: _____

Date: _____

Patient Signature