



Swedish Massage • Neuromuscular Therapy • Deep Tissue • Sports Massage • Pregnancy Massage • Hot Stone Massage

Have you ever received professional massage or related therapies? N Y - Describe _____

Have you ever received medical massage or other integrative therapies for medically related purposes?

(check all that apply)

- Muscle Pain Relief
- Muscle soreness issues related to lumbar disc conditions or SI joint conditions
- Cervical disc conditions
- Other: _____

Reason for your massage session today: _____

About your comfort during the session – Please indicate the areas of the body that you **DO NOT** want massaged by the therapist without informing you ahead of time*:

- Scalp
- Face side of neck
- Back of neck
- Shoulders
- Chest
- Under arms
- Side of rib cage
- Abdominal region
- Buttocks region
- Sacrum
- Hips
- Low back
- Mid back
- Upper back
- Upper Inner thigh
- Lower inner thigh

* Note: mid buttocks region and pubic area are always draped for men and women and the breast area remains draped for women; abdominal region and upper hip/buttocks region is only undraped while the massage is being performed on that region and then re-draped immediately. The mid buttocks region is never exposed. The following regions will be discussed and consented to ahead of time if the therapist finds that a medical massage procedure is indicated in that area: the front of the neck, breast region, pubic muscle attachments, inside the jaw, upper hamstring attachments and surrounding ligament region.

Therapists reserve the right to decline, discontinue, or restrict services based on any information provided in this form that may indicate that massage therapy would put the client's or therapist health at risk.

Please read and initial each item proving that you have read and understand each policy.

_____ I understand that when an appointment time is scheduled that time is reserved just for me with a therapist who cannot schedule other appointments with someone else during that time. **If I miss an appointment or I am unable to give 24-hour notice when I need to change or cancel my appointment, I agree to pay the therapist in full for the booked appointment time.** I agree that it is inconsiderate to refuse to pay or avoid paying for this pre-scheduled appointment time if I miss an appointment due to work or personal issues. I am aware that I will receive a bill in the mail for this missed appointment and I will pay it upon receipt;

_____ I am aware that Hands On Health will seek to compensate me if it is determined that your service provider or any other staff member makes a **scheduling error** on your behalf;

_____ I understand that **massage practitioners do not diagnose** illness, disease, or any physical or mental disorder. I acknowledge that massage is not a substitute for medical treatment, and it is recommended I see a primary healthcare provider for that service;

_____ I am aware of the document, **"your rights during your session"**. If I desire to read it and don't find it posted in the room where I receive treatment, I will ask for a copy to read. If necessary, I will ask for clarification about what I read;

_____ I understand that it is only fair to me and to my practitioner that **I speak up at any time during my session** if I have concerns or questions;

_____ I acknowledge that I am aware of Hands On Health's **HIPAA obligations** regarding the disclosure of my health information by Hands On health to other healthcare professionals. I agree that I will ask for clarification if I do not understand these policies. By law, I may at any time, request a copy of Hands On Health's privacy policy;

_____ I understand the Hands On Health provides therapeutic massage services only and that **inappropriate advances are not permitted at any time**. Both my therapist and/or I have the right to stop the session at any time if need be.

The information provided on this intake form is correct to the best of my ability. I have read, understand and will uphold all policies:

Signature _____ Date _____



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Confidential Intake Form

Doing a fabulous job for the Triangle Community means a lot to us. By checking ALL that apply, we'll know how we're doing and whom to thank! What factors prompted you to schedule your first visit with Hands On health (our specific practice and not massage in general)?

- | | |
|---|---|
| <input type="checkbox"/> Chair massage event | <input type="checkbox"/> Receptionist was helpful/patient |
| <input type="checkbox"/> A therapist was recommended. Who? _____ | <input type="checkbox"/> Staff medical massage training program |
| <input type="checkbox"/> Paper phone book | <input type="checkbox"/> Appointment was available when I wanted/needed |
| <input type="checkbox"/> On-line phone directory | <input type="checkbox"/> On-line search engine (i.e.: Google) |
| <input type="checkbox"/> Answered phone/returned call promptly | <input type="checkbox"/> Friendly Staff |
| <input type="checkbox"/> I heard about HOH from several resources | <input type="checkbox"/> Educational Website |
| <input type="checkbox"/> Referred by healthcare provider: _____ | <input type="checkbox"/> HOH website impressed me |
| Chiropractor, Acupuncturist, PT, other: _____ | <input type="checkbox"/> Therapist profiles on website |
| _____ | <input type="checkbox"/> Other (ie. friend): _____ |

Confidential Health Information:

Your Name: _____ Home Phone: _____
 Address: _____ Work Phone: _____
 City/State: _____ Zip: _____ Cell Phone: _____

Please add me to your educational/savings email – (Circle one) No Yes . Email: _____

Occupation: _____ Employer/Industry: _____

Date of Birth: ____/____/____ For insurance purposes: Age: ____ Sex: M F Height: ____ Weight: ____

Please check the following conditions that apply or have applied to you:

- | | | | |
|------------------------------------|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Broken bone(s) | <input type="checkbox"/> Bursitis/tendonitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Herpes zoster/shingles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cramps/spasm | <input type="checkbox"/> Heart problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Fatigue/insomnia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thoracic outlet | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Pregnancies: N Y |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Varicose veins | Other: _____ |

Describe and date ALL past surgeries, car accidents, head trauma (please use back of page if you need more space.)

Please list current medications/herbal supplements used and for what purpose

My primary physician is _____ **Phone:** _____

Does HOH have permission to contact/consult with these healthcare providers (only if necessary and with consent)? Y N

Please list all other health care providers in your wellness team (physical therapist, orthopedist, neurologist, chiropractor, etc)

