

Healing Hands Massage Therapy
Personal Data and Health Screen Intake

CONFIDENTIAL

Date _____
Name _____
Street _____
City _____ State _____ Zip _____
E-Mail _____
Phone (work) _____ (eve) _____ (cell) _____
Date of Birth ____/____/____ Marital Status- Please Circle: Single Married Divorced
Occupation _____ Employer _____
Name of Spouse/Significant Other/ Children's Names _____
Preferred Appointment Day and Time: _____
Referred By: Name: _____
Please Circle: Yellow Pages Sign Ad Other: _____
In Case of Emergency:
Name & Relationship _____ Phone _____

1. What is your previous experience with professional massage/other bodywork? Was it good or bad?

2. What types of massage/bodywork have you received?

3. What results do you wish to achieve from you massage sessions?

4. Are you currently under the care of a health care practitioner? Circle YES NO
If yes, for what condition?

5. Please list your physicians name, address and phone number:

Name: _____
Address: _____
Phone: _____

6. Please list all medications (including aspirin) that you are currently taking and list for what condition
Also include herbal/nutritional supplements

7. Do you experience frequent headaches? Yes or No If yes, please fill out the attached questionnaire
Are you a diabetic? YES or NO

Do you have high blood pressure? YES or NO

Do you have cardiac or circulatory problems? YES or NO

Do you have high cholesterol? YES or NO

8. Are you pregnant? _____ If yes, how far along? _____

9. Is there any area where you would like extra time spent?: _____

10. Any area where you seem to hold a lot of tension?: _____

11. Any area you'd like skipped? _____

12. What is your major complaint or muscular condition you would want to improve?: _____

13. What activities can aggravate this condition? _____

14. What activities improve your condition? _____

15. Have you used or tried any therapy products, seen a chiropractor, physical therapist, or physician for this?: _____

Continue Intake on Back Side

16. Lifestyle:

Describe your general health _____

Describe your exercise habits _____

Describe your general diet _____

Describe how well you sleep _____

How are your bowels _____

Posture assumed most of day _____

Do you wear: Circle contacts dentures hearing aid hair piece other, specify _____

Do you use or consume: Tobacco _____, Alcohol _____,

Caffeine _____, Recreational Drugs _____,

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc)? Explain.

Do you have any muscle pain and/or stiffness? Explain _____

Do you have any chronic, ongoing conditions that you deal with on a regular basis? Please explain. _____

Do you have any skin rashes or other skin problems right now? _____

Do you have any trouble lying on your back, front or turning over? _____

17. Medical Health History:

Please Explain and Give Specific Dates

Describe any injuries or accidents:

-More than 10 years ago:

-5-10 years ago:

-Less than 5 years ago:

Describe any surgeries or hospitalizations:

-More than 10 years ago:

-5-10 years ago:

-Less than 5 years ago:

What kind of care did you receive?

Do you consider that you have recovered from these events? Please explain

18. Health/Medical History: Please check 1 of the 3 columns that pertain to you

	Yes/Current	Past	No
High Blood Pressure	_____	_____	_____
Low Blood Pressure	_____	_____	_____
Heart Disease/Condition/Problems	_____	_____	_____
Stroke	_____	_____	_____
High Cholesterol/Arteriosclerosis	_____	_____	_____
Vertigo	_____	_____	_____
Varicose Veins	_____	_____	_____
Easy Bruising	_____	_____	_____
Phlebitis/Blood Clots/PAD	_____	_____	_____
Edema/Fluid Retention	_____	_____	_____
Epilepsy/Seizures/Convulsions	_____	_____	_____
Headaches	_____	_____	_____
Fractures	_____	_____	_____
HIV/AIDS	_____	_____	_____
Herpes I or II/shingles	_____	_____	_____

	Yes or current	Past	No
Hepatitis A, B or C			
Diabetes (indicate if have insulin pump)			
Intra Uterine Device			
Ulcer			
Back Pain			
Hip Pain			
Leg/foot pain			
Sciatica			
Spinal Problems			
Osteoporosis			
Herniated Disc/other disc problems			
Spinal Cord Injury			
Joint stiffness/swelling			
Spasms/cramps			
Strains/sprains			
TMJ/jaw pain			
Shoulder/arm/neck pain			
Abdominal pain			
Bone or disc disease			
Shortness or breath			
Fainting			
Cold feet or hands			
Cold Sweats			
Lymphedema			
Asthma			
Sinus Problems			
Skin Rash			
Athlete's Foot			
Abscess or open sore			
Skin Allergies/skin sensitivity			
Topical Allergies			
Allergies			
Cosmetic surgery			
Tendonitis, bursitis, etc			
PMS/painful menstruation			
Polio			
Multiple Sclerosis			
Cerebral palsy			
Muscular dystrophy			
Parkinson's disease			
Alzheimer			
Nerve Degeneration			
Cancer/Tumors-what type			
Infectious Disease			
Inner Ear Problem/Dizziness			
Mental Illness			

Healing Hands Massage Therapy
Policies and Disclaimer

Name: _____

Please initial after each policy to say that you read and understood the policy

All information you give to me will be treated confidentially. At no time will any of your information be sold to third parties. In order to maximize the effectiveness and safety of your massage session, please give feedback before, during and at the end of the session. This will help me to better understand your needs and how to better help you in the best possible way. _____

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. _____

I understand that giving 24 hours notice or more for cancellations or rescheduling will not result in any charge for that appointment. _____

Any missed appointment without 24 hours notice will result in a **\$50.00**
No Show fee. _____

Punctuality will assure full use of the allotted time. I allow 15 minutes for tardiness before I mark you as a No Show. I will make a phone call to the phone number on your chart to see if you are coming and if needed to reschedule. Any missed time due to you being late will be deducted from your session time. You will still be charged the same session price. If I am running late; you will still get your full session time

Missed appointment and clients running late is not only a hardship for your therapist but it's also unfair to those other clients who have an appointment after you or those on my waiting list who would have liked to have been notified of the opening. _____

Any returned check will result in a charge of \$25.00; I will then only be able to accept cash or charge for payment. _____

I have read the above information and will discuss it with my practitioner. I understand that massage/movement therapies I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage/movement therapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/movement 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 given should be construed as such. Because massage/movement therapy 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 as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so. I understand that massage/ movement therapies are designed to be health aids and do not constitute medical treatment. I understand that information exchanged during massage sessions is educational in nature and intended to help me become more familiar with and conscious of my own health status, and is to be used at my discretion. I take responsibility for alerting my therapists immediately if I am feeling ill. I understand that I cannot hold my practitioner liable for undisclosed conditions or irresponsible acts I might perform. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Signature _____ Date _____ Therapists in _____

Healing Hands Massage Therapy
Client Rights & Responsibilities /Client Information

My requirements of each client visiting my practice:

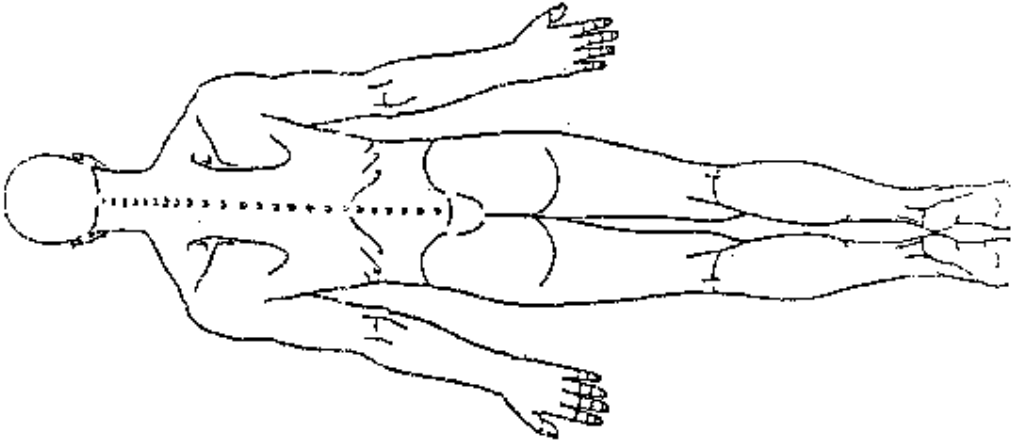
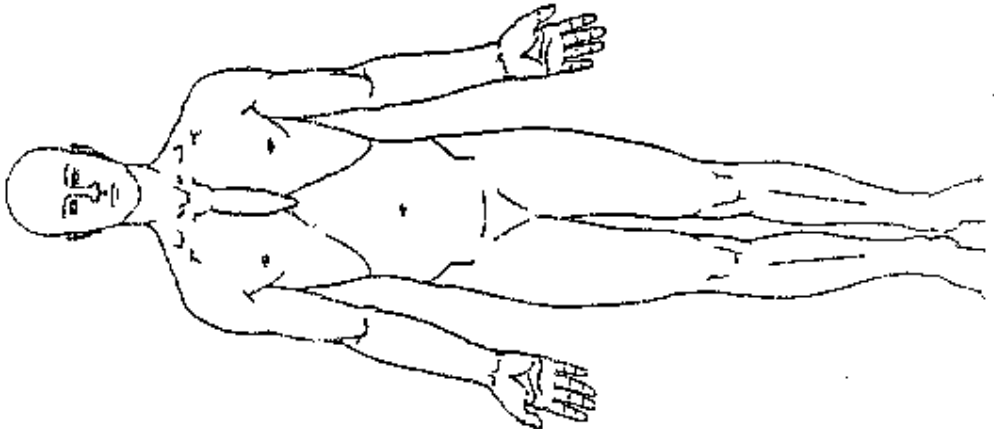
1. Sessions begin and end at scheduled times. Sessions begun late due to the client arriving late end the appointed time and are charged the full price.
2. Be present (not under the influence of alcohol or drugs). Your therapist can cancel you session if you are under the influence.
3. Clients are responsible for providing, to the best of their knowledge, an accurate and complete health history and update it when necessary. You are expected to accurately disclose all information necessary for massage therapy sessions.
4. If cancellation is necessary, please give 24-hour notice or you will be charged \$50.00 for the missed appointment unless you sent a replacement. Emergency cancellations are determined at the therapists' discretion.
5. Payment is expected at the time service is rendered.
6. On out-call or On-site chair massage appointments, if a client does not arrive within 15 minutes of the appointed time, they will be charged for the appointment time.
7. *Sexual harassment* is not tolerated at any time. If the therapist's safety feels compromised, the session will be stopped immediately.
8. *This office is a non-smoking environment.*
9. Be clean, having showered the same day as your appointment.
10. Do not eat a heavy meal less than two hours prior to the massage.
11. Clients are expected to treat their therapist with courteous and respect at all times.
12. Client can at any time change whom I am allowed to release information to or speak with.

What my clients can expect from their therapist:

1. I provide my clients with a competent and professional session each time they come for an appointment, addressing the client's specific needs for that session.
2. I provide my clients with a confidential setting where their privacy is always respected and maintained.
3. I am available to my clients between the hours of 11:00-6:00 Monday-Friday, 11:00-3:00 on Saturday. Clients may reach me through my answering service on a 24 hour basis on my office #-276-591-1390. You can reach me on my cell phone within reasonable hours-423-646-9961
4. I make return calls within 24-48 hours or less, unless I am out of town. At that time, this will be noted on my machine.
5. Clients are treated with respect and dignity.
6. I charge a fair price for my services.
7. I do not provide direct billing for insurance.
8. Payment is due at the time of the service unless you are a Gift Certificate recipient. I accept cash, checks, VISA, MC, Discover, and Debit Cards
9. I confirm Tuesday-Saturday appointments the day before, Monday's appointments on Fridays.
10. I perform services for which I am qualified (physically and emotionally) and able to do, and will refer you to appropriate specialists when work is not within my scope of practice and /or not in the client's best interest.
11. I keep accurate and confidential records and review them before each session.
12. I customize my sessions to meet the client's needs.
13. I stay current with information and techniques by reading, receiving regular sessions (of the same service I provide) and taking at least one workshop per year.
14. I respect all clients regardless of their age, gender, race, national origin, sexual orientation, religion, socio-economic status, body type, political affiliation, state of health or personal habits.
15. If cancellation is necessary, I will do so within 24-hours whenever possible. If an emergency arises and I can not cancel within 24-hours, I will give you a 20% discount on your next session.
16. My equipment and supplies are clean and safe.
17. Personal and professional boundaries are respected at all times.
18. If a client is dissatisfied with their massage session and no other arrangements or agreements could be agreed upon, a 50 % discount will be given for that day's session.
19. Clients are draped with a sheet and blanket at all times during the session. Only the parts of the body being worked on are exposed at any time. The genitals/breasts are never exposed or massaged.

Please sign and date below that you have read and reviewed your client rights and responsibilities

Name _____ Date _____



**Healing Hands Massage Therapy
Sarah E. Otis, CLMT, NCTMB**

Confidentiality

- A.** All information whether written, electronic, or otherwise pursuant to the massage session, referral and/or contact with current physician shall be kept confidential and shall not be disclosed without specific informed, written consent of the client.

- B.** All operations of Healing Hands Massage Therapy shall be conducted in accordance with state and federal confidentiality rules as defined in 42 C.F.R., Part 2.

- C.** The only circumstances under which client information may be disclosed without consent are (1) to medical personnel in the event or a bona fide medical emergency, (2) under an order of a court of competent jurisdiction.

- D.** All therapists and/or employees shall sign an agreement of confidentiality before conducting business pertinent to Healing Hands Massage Therapy's operations. This agreement shall be maintained in the personnel file of every client and therapist and updated annually.

Confidentiality Statement

I understand that all information pertinent to my treatment at Healing Hands Massage Therapy is strictly confidential. Now and in the future. I agree to maintain confidentiality at all times except as is required by section C. above.

Print Name: _____
Signature: _____
Date: _____

Healing Hands Massage Therapy Sarah E. Otis, CMT, LMT, NCBTMB
Bristol, VA 24201 423-646-9961
www.healinghandsmassage-bristol.com

General Release of Information

Today's Date: _____

Client Name: _____ *Please Print*

Please initial after each and sign at the bottom

1. I give Healing Hands Massage Therapy permission to speak or exchange any and all needed information pertaining to my current health conditions that I am seeing my regular physician for, if the need arises. _____

ANYTHING NON-HEALTH RELATED DISCUSSED DURING INTAKES OR SESSIONS WILL NEVER BE DISCUSSED WITH YOUR PHYSICIAN UNLESS YOU ARE POSING A HEALTH RISK TO YOURSELF.

2. I give Healing Hands Massage Therapy permission to call my physician, 911 or my Emergency Contact Person on file during an emergency situation for assistance. Only the needed information will be released for your care. _____

3. I give Healing Hands Massage Therapy permission to mail my physician a letter stating that I am being treated by Sarah E. Otis, CMT, LMT, NCBTMB, to give my physician an opportunity to voice any concerns about my current health conditions contraindicating massage.

Physician's Name, Address and Phone Number:

Emergency Contact, Address and Phone Number:

I understand that I may withdraw this consent at any time except to the extent that the authorized parties have already acted in reliance on it.

This authorization will automatically terminate in six (6) months, at that time you will need to sign another release of information

Name

Date