Lighthouse Massage - Client Intake Form

Lighthouse Massage 425 2nd Ave SW,Suite 101D,.Albany, OR.97321

PERSONAL INFORMATION

Name: _____ Date of birth: _____
Address: _____
City, State, Zip: _____
Home phone: _____ Cell phone:_____
Work phone, ext.: _____
Email:_____
Occupation: _____
Employer: _____
Employer address:_____
Marital status: _____
Referred by:_____
Emergency contact name (relationship): _____
Emergency contact phone: _____
Physician's name and phone: _____

MASSAGE PREFERENCES

Have you had a professional massage before? ❑ **Yes** ❑ **No**

If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)?:_____

How long have you been receiving massage therapy?: _____
Frequency of massages?: _____
What are your goals for treatment?: _____
Any areas you'd not want to be massaged?: _____

CURRENT HEALTH

Reason for initial visit: _____

Do you exercise regularly and/or participate in any sports? ❑ **Yes** ❑ **No**

If yes, what kind?: _____

_____

Do you perform any repetitive movement in your work, sports or hobby?

❑ **Yes** ❑ **No**

If yes, describe: _____

Do you sit for long hours at a workstation, computer, or driving? ❑ **Yes** ❑ **No**

If yes, describe: _____

Do you experience stress at work or in your personal life?

❑ **Yes** ❑ **No**

If yes, describe: _____

Are you experiencing tension, stiffness, discomfort or pain? ❑ **Yes** ❑ **No**

If yes, describe: _____

Have you recently had an injury, surgery, or areas of inflammation ❑ **Yes** ❑ **No**

If yes, describe: _____

Do you have sensitive skin? ❑ **Yes** ❑ **No**

Do you have any allergies to oils, lotions or fragrances? ❑ **Yes** ❑ **No**

If yes, explain: _____

List any medications you are currently taking: _____

_____

_____

List any known allergies:

_____

_____

_____

_____

CLIENT SIGNATURE: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CHECK ALL THAT APPLY

MUSCULOSKELETAL

❑ Bone or joint disease
❑ Arthritis/Gout
❑ Lupus
❑ Migraines/Headaches
❑ Tendonitis/Bursitis
❑ Jaw Pain (TMJ)
❑ Spinal Problems
❑ Osteoporosis

CIRCULATORY

❑ Heart Condition
❑ Blood Clots
❑ Lymphedema
❑ Phlebitis/Varicose Veins
❑ High/Low Blood Pressure
❑ Thrombosis/Embolism

RESPIRATORY

❑ Breathing Difficulty/Asthma
❑ Allergies, specify:
❑ Emphysema
❑ Sinus Problems

NERVOUS SYSTEM

❑ Shingles
❑ Pinched Nerve
❑ Paralysis
❑ Parkinson's Disease
❑ Numbness/Tingling
❑ Chronic Pain
❑ Multiple Sclerosis

REPRODUCTIVE

❑ Pregnant, week _____
❑ Ovarian/Menstrual Problems
❑ Prostate issues

SKIN

❑ Allergies, specify:
❑ Cosmetic Surgery
❑ Herpes/Cold Sores
❑ Rashes
❑ Athlete's Foot

DIGESTIVE

❑ Irritable Bowel Syndrome
❑ Colitis
❑ Ulcers
❑ Bladder/Kidney Ailment
❑ Crohn's Disease

HEAD/NECK

❑ Headaches/Migraines
❑ Ringing in Ears
❑ Vision Problems
❑ Vertigo/Dizziness
❑ Hearing Loss
❑ Vision Loss

PSYCHOLOGICAL

❑ Anxiety/Stress/PTSD
❑ Depression

OTHER

❑ Cancer/Tumors
❑ Dentures
❑ Drug/Alcohol/Tobacco Use
❑ Diabetes
❑ Contact Lenses
❑ Hearing Aids
❑ Any other medical condition(s) not listed:

_____

_____

_____

_____

Please explain any of the conditions that you have marked above:

_____

_____

_____

_____

_____

_____

INSURANCE INFORMATION

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Client's Name: _____

Date: _____

Insurance/Claim ID#: _____

Date of Injury: _____

Is your condition the result of an auto accident?

❑ Yes ❑ No If yes, in what state did accident occur?: _____

❑ A work injury? ❑ A health condition?

❑ Other: _____

What type of insurance do you have that may cover you for this condition? (check all that apply)

❑ Auto ❑ Workers' Compensation/State Industrial

❑ Liability ❑ Health

Was a police/accident report filed? ❑ Yes ❑ No

Client' relation to insured?

❑ Self ❑ Spouse ❑ Partner ❑ Child ❑ Other

Insured's full name (if not client):_____

Insured's date of birth: _____

Insured's employer: _____

Ins. ID #: _____

❑ Male ❑ Female ☐ Unknown/Other

❑ Single ❑ Married ❑ Partnered ❑ Other

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Employer's name/school name: _____

Address: _____

Phone: _____

Primary insurance plan name: _____

Group number plan number: _____

Phone: _____

Plan's billing address: _____

City: _____ State: _____ Zip: _____

Ins. Adjuster Name: _____

SECONDARY INSURANCE INFORMATION

Who is your attending physician?: _____

Address: _____

City: _____ State: _____ Zip: _____

Office phone: _____

Fax: _____

Permission to consult with _____

regarding _____ Your initials _____

For accident: Has an attorney been retained? ❑ Yes ❑ No

If yes Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone: _____

Fax:_____

CLIENT AGREEMENT

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 of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that Massage Magazine Insurance Plus has provided this form as a reference and is not held liable for any services provided.

Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist,

_____ for services billed.

Signature: _____

Date: _____

Signature of parent/legal guardian (if client is a minor):

_____

RELEASE OF MEDICAL RECORDS

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, health care providers, and insurance case managers, for the purposes of processing my claims.

Signature: _____

Date: _____

Signature of parent/legal guardian (if client is a minor):

_____

COVID-19 AGREEMENT

I knowingly and willingly consent to have massage therapy during the COVID-19 pandemic. I understand that the COVID-19 virus can have a long incubation period, during which carriers of the virus may not show symptoms and can still be highly contagious. I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever temperature over 99.6°F degrees
- Chills with or without body aches
- Shortness of breath
- New loss of sense of taste or smell
- Unexplained sores on soles of feet
- Unusual fatigue
- Cough
- Sore throat

Please seek immediate medical attention if you are displaying any severe signs of COVID-19.

I confirm that I have not been in close contact with anyone exhibiting the above COVID-19 symptoms within the past 14 days. I further confirm that I am not currently living with anyone who is sick or who is quarantined. To prevent the spread of contagious viruses and to help protect each other, I understand that I will have to follow the massage therapist's guidelines.

Signature: _____

Date: _____

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)

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