Baltimore Orthopedic Massage
260 Gatway Dr. Bel Air, MD. 21014
(443) 902-5304

Client Intake

Full Name: _____ Date:
Street Address:
City: _____ State: _____ Zip:
DOB: _____ Referred by:

Emergency Contact: _____ Phone #:
Relationship: _____

Please indicate the number to leave messages.
(Home / Work / Cell): _____
Email(s):_____

1) **Consent and Waiver**

I **consent to receive therapeutic massage** and will not hold my therapist or Baltimore Orthopedic Massage responsible for any personal injury or loss of property. I understand that I will be asked questions regarding my physical state including present condition as well as past medical history, and that I may need to provide medical records. I understand that there are medical conditions for which massage therapy would be contraindicated and **that I may need to obtain written permission from my physician** before receiving massage. I authorize Baltimore Orthopedic Massage to release Protected Health Information (PHI) as requested by my health insurance carrier, physician, to coordinate care or as required by law. **All information disclosed will be kept strictly confidential**.

2) **Not a Substitute for a Doctor's Care**

I understand that **massage therapy is not a substitute for medical treatment or medications**, and that it is recommended that I am concurrently working with my Primary Caregiver for any condition I may have. I am aware that the therapist does not diagnose illness, prescribe medications or supplements, and that spinal manipulations are not part of massage therapy.

3) **Cancelation and Payment**

I understand that **payment is due at the time of service**. Appointments that are **canceled within 24 hours** of the scheduled session will result in a charge for the **full price** of the treatment session scheduled. Emergency cancellations may be determined at the therapist's discretion. Thank you and enjoy!

Signature: Date:

Print Name:

MEDICAL HEALTH HISTORY

Primary Physician:

Phone: _____ Date of last physical:

Medications (e.g. pain relievers, muscle relaxants, blood thinners, etc...):

Have you ever received a therapeutic massage before? (Yes / No) How often?
Why have you chosen therapeutic massage at this time?
What are your expectations?

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

Head / Face / Jaw / Mid - Low Back / Shoulders / Neck / Abdomen / Legs / Feet / Arms / Hands
Other:

Daily pain: Circle appropriate number

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
None Extreme

Conditions & Symptoms Please Indicate:

Acne	Circulation Issues*	Heart Murmur	**Pregnancy**: _____/M
Allergies	Cold Sweats	Hemophilia	Psoriasis
Anemia	Congestive Heart	Hepatitis	Psychiatric
Angina	Failure (CHF)	Herpes	Respiratory
Anxiety	Depression	Hives	Seizures/Epilepsy
Arteriosclerosis	Dermatitis	Hypertension	Sinus Issues
Arthritis	Diabetes	**Injuries**	Skin Conditions
Asthma	Digestion Problems	Joint Problems	Smoking
Athlete's Foot	Dizziness	Kidney/Urinary	Stress
Bleeding	Eczema	Liver/Gall Bladder	**Surgery**
Blood Pressure	**Edema**	Neuritis	Ulcers
(High/Low)	Endocrine Issues	Muscle Strain/Sprain	**Varicose Veins**
Bruising	Fainting	**Osteoporosis**	**Vertebral/Disc**
Bursitis	Fatigue	**Phlebitis/Blood Clots**	**Problems***
Cancer: _____	Headaches	Pins	Warts
Cardiac Issues*	Heart Attack	Pacemaker	

*Describe: