

## 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.

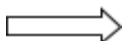
### 3) Cancellation and Payment

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

\*Describe: