

THERAPEUTIC MASSAGE & BODYWORKS OF WNY
New Client Intake Form

WELCOME

Please tell us about yourself...

Today's date _____ Referred by _____

Name _____

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Phone # HOME _____ WORK _____

CELL _____

Birth date ___/___/___ SS # ___/___/___

Marital Status : SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOWED

Spouse's Name _____

In Case of Emergency please call _____

Phone _____

Physician's Name _____

Chiropractor's Name _____

Employer _____

Occupation _____

INSURANCE INFORMATION

Insurance Company Name _____

Insured's Name _____

Insured's SS # ___/___/___ Relation _____

Insured's Employer _____

PLEASE INITIAL & DATE _____

REASON FOR YOUR VISIT . . .

- _yes _no Is this visit related to a Car Accident or Work Injury?**
- _yes _no Have you ever had a professional massage?**
- _yes _no Do you suffer from frequent headaches?**
- _yes _no Are you pregnant?**
- _yes _no Are you wearing contact lenses?**
- _yes _no Are you diabetic?**
- _yes _no Do you suffer from arthritis?**
- _yes _no Do you have high blood pressure?**
- _yes _no If yes, are you taking Medication for high blood pressure?**
- _yes _no Do you suffer from seizures or epilepsy?**
- _yes _no Do you have varicose veins?**
- _yes _no Do you have any contagious diseases?**
- _yes _no Do you have any allergies?**
- _yes _no Do you bruise easily?**

- _yes _no Have you had any broken bones in the past two years?**
- _yes _no Do you suffer from stress?**
- _yes _no Do you have tension/soreness in specific areas?**
If so, in what areas _____
- _yes _no Do you have cardiac or circulatory problems?**
- _yes _no Do you suffer from back pain?**
- _yes _no Do you have numbness/stabbing pain anywhere?**
- _yes _no Are you sensitive to touch/pressure ?**

- _yes _no Have you ever had surgery?**
If so, please explain _____

- _yes _no Do you have any other medical conditions, or are you taking any medications I should know about?**

PLEASE INITIAL & DATE _____

Please take a moment to carefully read the following information and sign below.

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

I understand that massage/bodyworks I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodyworks should not be construed as a substitute for medical examination, diagnosis, or treatment and 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/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescreen, 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/bodywork 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. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Please note our new office policies, effective June 1, 2010.

CANCELLATION POLICY

We are happy to accommodate your needs and understand unforeseen circumstances can occur. In the event that you need to cancel or change your appointment, we respectfully request a 24 hour notice. As a courtesy, we allow a one-time grace period of the cancellation policy without penalty. Other instances will be charged a \$35 Service Fee.

NO SHOW POLICY

If you do not show up for an appointment or do not give any cancellation notice, you will be charged a \$50 Service Fee. Future appointments may be denied if payment is not received. If there are two No-Show appointments within a 6 month period, an appointment hold will be placed on your account for 6 months.

TRADITIONAL BLUE PATIENTS [Effective January 1, 2010]

All Blue Cross/Blue Shield Traditional Blue patients who do not show up for appointments and do not call to cancel with 24 hours notice, you will be charged for that appointment.

GIFT CERTIFICATE POLICY

When booking an appointment with a gift certificate, we will ask for your gift certificate number, located on your gift certificate. As a reminder, gift certificates are valid for six months from the date of purchase. If you do not show up and do not cancel an appointment made with a gift certificate, that gift certificate will be null and void.

ILLNESS

In the case of an illness please reschedule your massage session. This is both for the health of the therapist and that of others receiving massage in this office. Usually massage can also exacerbate your illness, due to the circulation enhancing qualities of massage.

Initial & Date:
