

**CONFIDENTIAL INTAKE (Without Insurance/Benefits)**

Please Print

Last Name \_\_\_\_\_ Hm Phone \_\_\_\_\_  
 First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Wk Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_  
 Occupation/Activities \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  F  M  
 How did you learn about us? \_\_\_\_\_

**HEALTH HISTORY**

Mark any condition that applies to you now or in the past. Please use 'C' for current, 'P' for past

<input type="checkbox"/> Allergy to Nut Oils	<input type="checkbox"/> Contagious Conditions	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Decreased Sensation / Numb	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Muscle Sprain / Strain
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Skin Infections
<input type="checkbox"/> Cancer / Tumor	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Contact Lens	<input type="checkbox"/> Hypo or Hyperglycemia	<input type="checkbox"/> Other Conditions _____

Other relevant health history? \_\_\_\_\_

**Accidents, Injuries or Surgeries:**

Less than 5 years ago \_\_\_\_\_

More than 5 years ago \_\_\_\_\_

Are you currently receiving medical or chiropractic care?  Yes  No

If yes, please explain \_\_\_\_\_

Are you taking any medications (prescription & over-the-counter)?  Yes  No

If yes, please explain \_\_\_\_\_

Exercise? \_\_\_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_

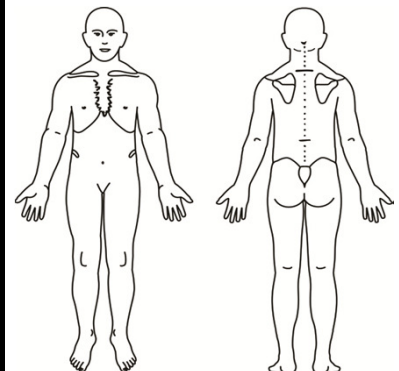
Have you received massage before?  Yes  No

**READ, INITIAL EACH AND SIGN BELOW!**

- ▶ All information provided is complete and accurate; I will notify MTM of any changes. Any changes in my physical condition will be told to my treating LMP prior to my treatment.
- ▶ Massage therapists do not diagnose illness or disease, or prescribe treatments.
- ▶ **Payment is due at the time of service.**
- ▶ **A \$15.00 billing fee is charged for payment not made at time of service.**
- ▶ MTM charges \$25.00, plus bank fees for all returned checks.
- ▶ An unpaid balance is due 30 days from statement date. A 1.5% interest or a minimum of \$1.00 per month will be charged until the balance due is paid. Rebilling fees may be added. Additional court, attorney or collection agency fees may be charged, up to 50%, if applicable.
- ▶ We reserve the right to change the terms and conditions at any time.
- ▶ I have been given or offered and read the privacy/HIPAA information for MTM.
- ▶ In an emergency, call immediately to reschedule
- ▶ **Missed or cancelled appointments without giving a 24 hour notice will be charged a \$25.00 fee.**

Rev 4/26/11

**Please mark areas of pain/stress/tension:**



Guardian or

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_