Therapeutic Impressions, LLC
Client Intake Form

Name_____Address_____City_____State_____
Zip Code_____ DOB_____ Phone -Cell _____ Home_____
E-mail_____ Occupation _____Work Responsibilities _____
_____
Primary Care Provider_____ Phone _____ Emergency Contact_____
Relationship _____Phone - work _____ home _____ cell_____
Who can we thank for your referral?_____

Current Health:
Have you received massage therapy before? __ yes __no Frequency:_____
Reason for today's visit: _____
Desired Result for today's session: _____
Current Medications: (include over-the counter and herbal remedies)_____
_____
_____
Stress reduction/exercise activities_____ Frequency: _____
Do you have any open cuts, bruising, or rashes?_____ If yes: location_____ Have you been treated by a doctor? _____
Allergies/Sensitivities: ___nuts ___oils ___detergents ___ fruits ___ shellfish ____ latex ___lotions ___ scents ___ If you answered yes to any of these please Describe: _____

Please circle all current conditions that pertain to you. This will allow us to provide the best custom treatment for you.

Musculo-skeletal
___tendinitis/bursitis
___arthritis
___osteoporosis/osteopenia
___fractured bones
___firbromyalgia
___Chronic fatigue Syndrome
___headaches/migraines
Frequency:_____
___TMJ/Jaw pain
___numbness/tingling
Location : _____
___hernia
___back/hip/leg pain
___neck/shoulder pain
___sprain/strain
___chronic subluxation/dislocation
___thoracic outlet syndrome

Medical Treatments
___chemotherapy / radiation
___cortisone injections
When was it?_____

Respiratory
___asthma/COPD
___sinus problems
___tuberculosis
___smoker
___allergies

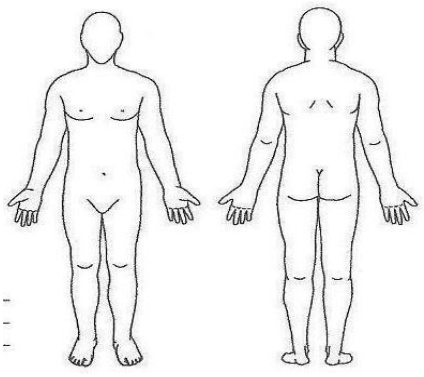
Other
___HIV/AIDS
___Hepatitis
___contact lenses
___hearing aid/problem
___cancer/tumor
___diabetes
___eating disorders
___depression
___thyroid disease
___surgery
___metal implants
___claustrophobia
___Lyme disease

Circulatory
___cardiac problems
___varicose veins
___blood clots
___High/low blood pressure
___stroke
___thrombosis
___lymph edema
___hemophilia

Skin
___allergies
___rashes
___athletes foot
___warts
___acne
___sensitivity
___bruising
___open cuts

Reproductive
Are you pregnant?_____trimester_____
___hysterectomy

Mark figures of all areas of discomfort:
Rate Severity of all symptom areas from 1-10:
(1 = I feel like a newborn baby, 10 = Put me out of my misery!)
1 2 3 4 5 6 7 8 9 10



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Previous Health History
Surgeries:_____
_____
Major Illnesses:_____
Fractures: _____
Are you currently experiencing any symptoms from the above?_____

Contract for Care
Please Read thoroughly and Sign:
I understand that Massage Therapy is not a substitution for medical treatment. Massage Therapists are not legally licensed to diagnose mental or physical illness, disease or disorder, nor do they prescribe pharmaceuticals or perform chiropractic manipulations. Massage Therapists are not qualified to give nutritional advice.

I agree to fully participate as a member of my health care team by providing an accurate medical history form and will continue to update my Massage Therapist of any changes in my health status, including medications.

I will immediately inform the Massage Therapist if I become uncomfortable at any point during the massage treatment.

I respect the rights of the Massage Therapist to discontinue or deny treatment.

Cancellation Policy:
24 hour notice for cancellation of appointments is appreciated. We reserve the right to charge a fee for habitual same day cancellations or no shows. Please understand this time is reserved for you and with proper notice we are able to schedule other clients into that appointment time. We understand that emergencies do arise and do not normally charge for cancellations. If possible, we would appreciate you filling your appointment slot with a friend or family member. They will thank you for it!

Acknowledgement of Receipt of our Notice of Privacy Practices:
By signing below, I acknowledge that I have been provided with a copy of The *Therapeutic Impressions* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *Therapeutic Impressions* and how I may obtain access to and control this information.
1. Please list who you want to have access to your pertinent medical information._____
2. May we leave a message on your answering machine?_____
3. Preferred method of contact: Home_____Cell_____Work_____

Client Name (please print)_____
Signature_____Date_____

Parent/Guardian Signature (if client is under 18 years of age)
_____