HANDS ON
ACUPUNCTURE & MASSAGE THERAPY
P.C

1239 N. Country Road, Suite 3 Stony Brook, NY 11790
www.HandsOnAcupuncture.com

Medical Massage Client Intake

Client Contact Information

Client Name: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/Health-care Provider name: _____ Phone: _____
Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐
Do you have a physician referral/prescription? Yes ☐ No ☐
Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form. Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐
How recently? _____
What types of massage/bodywork do you prefer? _____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
_____
_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:
_____
_____

List the medications you currently take:
_____
_____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

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Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past.

Current Past Muscle or joint pain

Current Past Muscle or joint stiffness

Current Past Numbness or tingling

Current Past Swelling

Current Pas Bruise Easily

Current Past Sensitive to touch/pressure

Current Past High/Low blood pressure

Current Past Stroke, heart attack

Current Past Varicose veins

Current Past Shortness of breath, asthma

Current Past Cancer

Current Past Neurological (e.g. MS, Parkinson's, chronic pain)

Current Past Epilepsy, seizures

Current Past Headaches, Migraines

Current Past Dizziness, ringing in the ears

Current Past Digestive conditions (e.g. Crohn's, IBS)

Current Past Gas, bloating, constipation

Current Past Kidney disease, infection

Current Past Arthritis (rheumatoid, osteoarthritis)

Current Past Osteoporosis, degenerative spine/disk

Current Past Scoliosis

Current Past Broken bones

Current Past Allergies

Current Past Diabetes

Current Past Endocrine/thyroid conditions

Current Past Depression, anxiety

Current Past Memory loss, confusion, easily overwhelmed

Comments:

_____

_____

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Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____