

Instructions:

Included is two sheets each with a front and back.

- To save time, it is suggested you fill these out before you arrive.
- The second sheet should take less than 2 minutes to fill out, and should be done as close to the session (or at the office) to give an accurate evaluation immediately preceding your session.

The first is a client intake/Client information/Health History:

- This is to be filled out before your first session, and updated annually or if there are changes.
- Please fill out as much as possible. While not everything is required, it helps us customize the session for you, ensure we are aware of any health issue that may come up. Some things you may not think are important but could change the course of the massage. Some things you may opt to leave out, but that is up to you... Thank You

The Second is a daily sign in and therapist notes:

- The front is to be filled out by the client before each session
- The back is filled out by the therapist following the session
- This includes your current information as changed or needed for the current session. Including areas needing focused on and avoided the this session.

Massage Therapy Sign In

Name: _____ Phone ☎: _____

What are your goals for today's session: Relaxation: _____ Pain/Tension relief: _____ Flexibility: _____

Other: _____ Medical Deep Tissue Heat / Ice Paraffin Dip Aroma Therapy Foot Soak

Areas of interest & character of work/massage to be performed

Focus on:

Avoid:

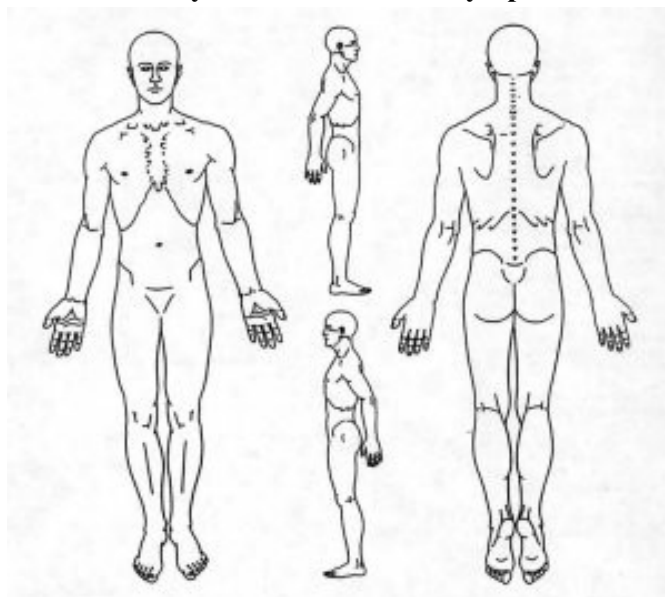
i.e. Back, Hands, Feet, Head, Arms, Legs, Glutes, Same, etc

Also include things you would like changed compared with your last visit: deeper/lighter pressure.

slower/faster, more/less stretching, trigger points, reflexology, etc.

(Feather light touch)

Precisely mark the areas of symptoms



Name or circle your conditions below and circle the severity "0" being perfect and "10 being worst possible.

Headache/Migraine 0 1 2 3 4 5 6 7 8 9 10

Neck 0 1 2 3 4 5 6 7 8 9 10

Mid Back 0 1 2 3 4 5 6 7 8 9 10

Low Back 0 1 2 3 4 5 6 7 8 9 10

_____ 0 1 2 3 4 5 6 7 8 9 10

_____ 0 1 2 3 4 5 6 7 8 9 10

Have you noticed any changes since your last visit?

What makes your complaints better or worse?

Since your last visit

(including those not the area of focus)

Any new conditions (including: Cold/Flu, Inflammation, Cuts/Burns/Bruises, Rash/Poison Ivy, Sunburn, Sprains/Strains or other Injuries) Yes/No Currently under a Dr's care Yes/No

Is it affecting your daily routine Yes/No

Have you seen another therapist Yes/No

Taking any Medicine/Supplements Yes/No

Have you seen a Dr on these issues Yes/No If you answered yes describe in notes below.

If you are missing work when was the last date worked: _____

Notes: _____

Signed: _____ Date: _____ **(STOP)**

Therapists Use ONLY

SOAP/CARE Notes*

Date: _____ Therapist _____

____ Basic/Swedish Massage (97124); ____ Manual Therapy (97140 - Advanced Massage Therapy Techniques); ____ Heat / Ice (97010)

Referral Diagnosis / ICD: _____

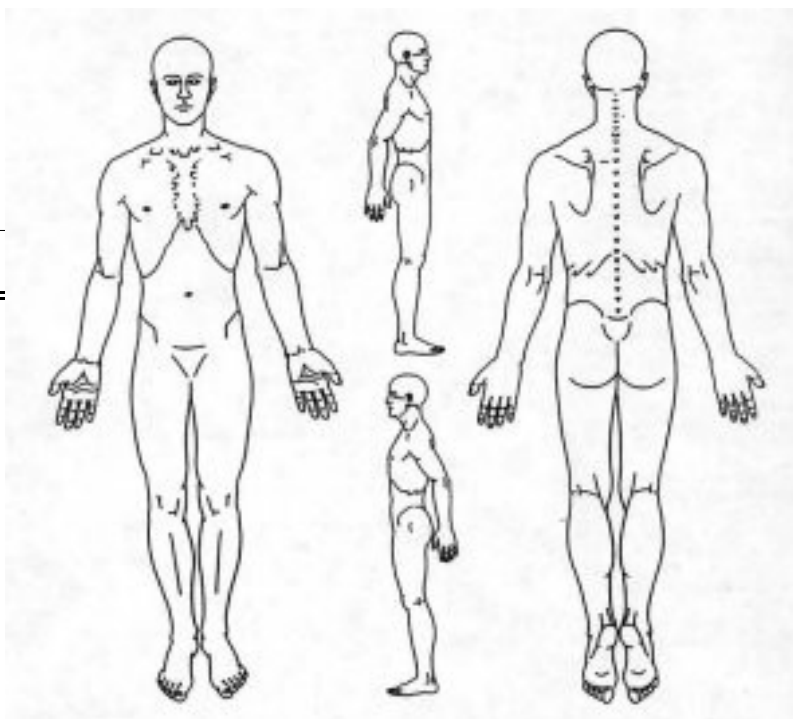
(40) – Manual Therapy (24) – Basic/Swedish SwM – Swedish Massage bilat – both sides EC – Elbow Compression ® – Right PC – Palmar Compression	PS – Palmar Stretches KK – Kneading ART – Active Release FmS – Forearm Stripping ES Elbow Stripping TS – Thumb/Finger Stripping ACU – Acupressure	MFR – Myofascial Release CST – Cranial Sacral Pol – Polarity DTS – Deep Tissue Sculpting LD – Lymphatic Drainage (M) – Massage GFB – General Full Body	Sp – Spasm TP – Trigger Point I – Inflammation noc – Nocturnal px – pain ITB – Iliotibial Band xff/cff – Cross Fiber Friction
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For Diagram:

- A – Adhesion
- ~ – Spasm
- ' – Tender point
- O – Tight Band
- E – Edema
- X – Trigger Point
- P – Pain

SOAP

Medical



Homework:

* Subjective; Objective; Assessment & Plan – C =condition of client; A=action taken; R=response of client; E=evaluation

Client information: Massage Therapy

Name: _____ Date of Birth: _____

Address: _____ Local / Frequent Visitor? _____

City: _____ State: _____ Zip: _____

Permanent Address: _____ Zip: _____

Phone: (H) _____ (W) _____ (Textable) _____

Email Address: _____

Occupation: _____

How did you hear about us: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Have you had massages before (describe) _____

When was your last professional massage _____

Exercise (type & frequency) _____ Training

List any medications and supplements you are taking _____

Are you under a Dr's Care* Yes / No : Physician: _____ Phone: _____

**If you are being referred by a physician, please bring your referral letter with diagnosis (Including ICD) – May be required to be covered by insurance*

Do you currently or anytime in the past have any of the following conditions

- | | | | |
|--|--|---|--|
| (Check for yes) | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental/Emotional | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation Prob. | <input type="checkbox"/> Distress | <input type="checkbox"/> Spinal injuries |
| <input type="checkbox"/> Accident | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> G.I. Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ticklish |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnant/Trying | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sensitive to perfumes, | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> lotions, or oils | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Sensitivity | |

If you checked yes, please describe, give relevant dates, and list other health problems below:

Smoke _____ packs/week

Drink _____ glasses of water per day

Drink _____ Alcohol drinks/week

Drink _____ servings of caffeine/week

Recreational Drugs: Never – Occasionally – Frequently _____

Do you have a special diet? Low Fat / Low Carb / Vegetarian / _____

Read and sign back of form.

Pg. 1 of 2

(Over)

- I understand that massage is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing energy flow.
- I understand the massage therapist does not diagnose illness, disease, or any other physical or pharmaceuticals/supplements
- I understand that massage therapy is not a substitute for medical treatment and/or diagnosis, and that it is recommended that I see a physician for any ailments that I may have, and before I start any exercise regiment.
- The massage therapist will only provide massage in the course of work trained.
- If the client lists any contraindications for therapeutic massage, the therapist will be granted the right to contact there physician for medical release prior to massage.
- I understand that any sexually suggestive remarks or advances made by me will result in immediate termination of the session. I will be liable for payment in full.
- I understand that if I cancel my appointment without giving 24-Hour advanced notice, I will be liable for the full payment for that session.
- All information is strictly confidential and will not be sold or given out. It may be shared with insurance companies and insurance companies on file.
- I will communicate with the therapist during the massage to indicate pain, pace pressure, and other issues during the massage so the therapist can tailor the session and make it appropriate and effective for me the client

I would like to receive promotions from this office/therapist via: Email, Phone, Mail, Social Media
 If it is important that we not contact you be a particular method, please inform your therapist.

I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

SIGNATURE _____ DATE _____

If the client is under the age of 18, the parent or guardian must sign below authorizing care, attesting that the information provided is accurate and true, and will be financially responsible for all services performed.

Parent/Guardian's Printed Name: _____

Relationship: _____

 Signature of parent/guardian

 Date

(Office Use) Therapist _____ NOTES:

