Client Intake **Therapy for the Body Massage, Michelle Kwok LMT**

Patient Information

Name: _____
Last First MI

Address: _____
Number Street City State

Phone: (___) _____ (___) _____ Email: _____

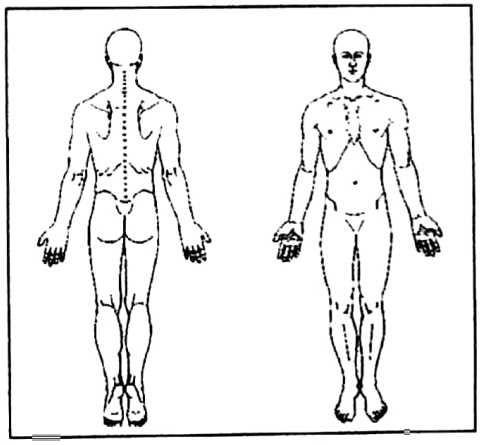
Date of Birth: _____ Occupation: _____ Best contact method _____

Emergency Contact: _____ Relation: _____ Phone: (___) _____

Referred by: _____

Symptoms

Please mark an "X" at any area of discomfort on the diagram.



Please circle which, if any, of the below activities are painful.

Sitting	Walking
Bending	Twisting
Standing	Running
Lying Down	Lifting

Please circle your level of discomfort.

1 2 3 4 5 6 7 8 9 10

Low Severe

Please circle the type of discomfort you experience.

Shooting	Tingling
Dull	Sharp
Stiff	Achy
Numb	Throbbing
Weak	Tenderness
Burning	Pain
Spasm	Tightness
Fatigue	Itching
Radiating	Difficulty Sleeping

Please describe your chief health concern(s): _____

How long have you had these symptoms? _____

What aggravates your discomfort? _____

What relieves your discomfort? _____

Health History

Have you had any recent illnesses, accidents or surgeries? ( )Y ( )N If yes, please explain_____

Have you ever received a professional massage? ( )Y ( )N If yes, frequency & type:_____

List All Current Medications, Vitamins, and Supplements

List stress reduction & exercise activities: _____

Do you have problems with any of the following? Please mark "C" for current conditions, and "P" for Past:

( ) Diabetes _____
( ) Skin Problems/Rashes _____
( ) Circulation Problems _____
( ) Cancer _____
( ) Chronic Illness _____
( ) High Blood Pressure _____
( ) Infection _____
( ) Headaches _____
( ) Allergies _____
( ) Pregnancy _____
( ) Heart Disease _____
( ) Arthritis _____
( ) Seizures _____
( ) Other _____

Privacy Policies Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Date: _____ Please initial: _____

I authorize Michelle Kwok LMT to consult other healthcare practitioners in regards to my therapy when necessary to provide the highest level of care. **Yes ☐ No ☐**

Massage Therapy Informed Consent

I,_____ , (client) understand that massage therapy provided by, Michelle Kwok LMT is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume those risks.

Client Signature_____ Date _____

Name of Insurance Company _____

Address _____ Phone Number ( ) _____

Claim/Policy No_____ Contact Person: _____

Name of Insured: _____ DOB _____

Relation to Patient: _____Phone Number ( ) _____

Address: _____

Referring Physician/Medical Professional: _____

Phone Number ( ) _____ Date of Injury _____

Employer _____