True Health Massage Therapy
Mayte Camacho LMT
Client Initials:_____

Massage Intake Form

Name:_____ Date:_____ DOB:_____
Address:(city, state, zip code)_____
_____
Phone number:(cell, work, or home) _____
Email: _____
Referred by:_____
Marital Status

Single	Married	Divorced	Separated	Widowed	Domestic partner

Gender:_____ Age:_____ Height:_____ Weight:_____

Occupation:_____

Emergency Contact:

Name:_____ Number:_____ Relation:_____

Primary Care Physician:
Name _____ Number _____
Address _____

Have you had a professional massage before?
Yes? Date of last treatment:_____ or No
Reason for visit: _____
_____
_____

What kind of treatments have you tried? Have they helped alleviate the problem?

Illnesses:

Surgeries:

Significant Traumas (car accident, falls…)

Do you or have you ever had any infectious disease? If yes, please describe:

Allergies/Hypersensitivities:

Hobbies/Recreational Activities:

Do you exercise regularly? If yes, describe:

Any unusual stresses lately?

Favorite/least favorite time of year:

Have you traveled abroad in the last year? If so, where?

Do you smoke Y/N____ how often? ____ # per day ___ # per week, or only special occasions. 3

Do you drink alcohol Y/N how often? ____ oz. per day ____ oz. per week, or only special occasions.
Caffeinated drinks per day ___ or per week ____

Emotional Health: (happy, sad, chronic depression, anxiety, stressed, worried, anger, irritable, fearful, careless, etc.)

Sleep: (can't fall asleep, trouble staying asleep, frequent nighttime urination, vivid dreams, nightmares, etc.)

Body temperature: (do you run hot or cold, sweat easily, cold hands/feet)

Thirst: (crave cold or hot drinks, always or never thirsty, dry mouth or too much salivation, etc.)

In your own words, please describe the main health problems for which you are seeking treatment:

Onset:

When did this begin?

How did it happen?

When does it feel worse? Better? Do certain movements help or hurt?

What is the quality of pain? (sharp, stabby, dull, achey, sore..)

Does the pain radiate? Yes or no, if yes, where?

Is your pain constant or sporadic?

Medications

(Prescriptions, over the counter, vitamins, **herbs**, etc. regularly taken in last 3 months)

Medication/Dose	Reason

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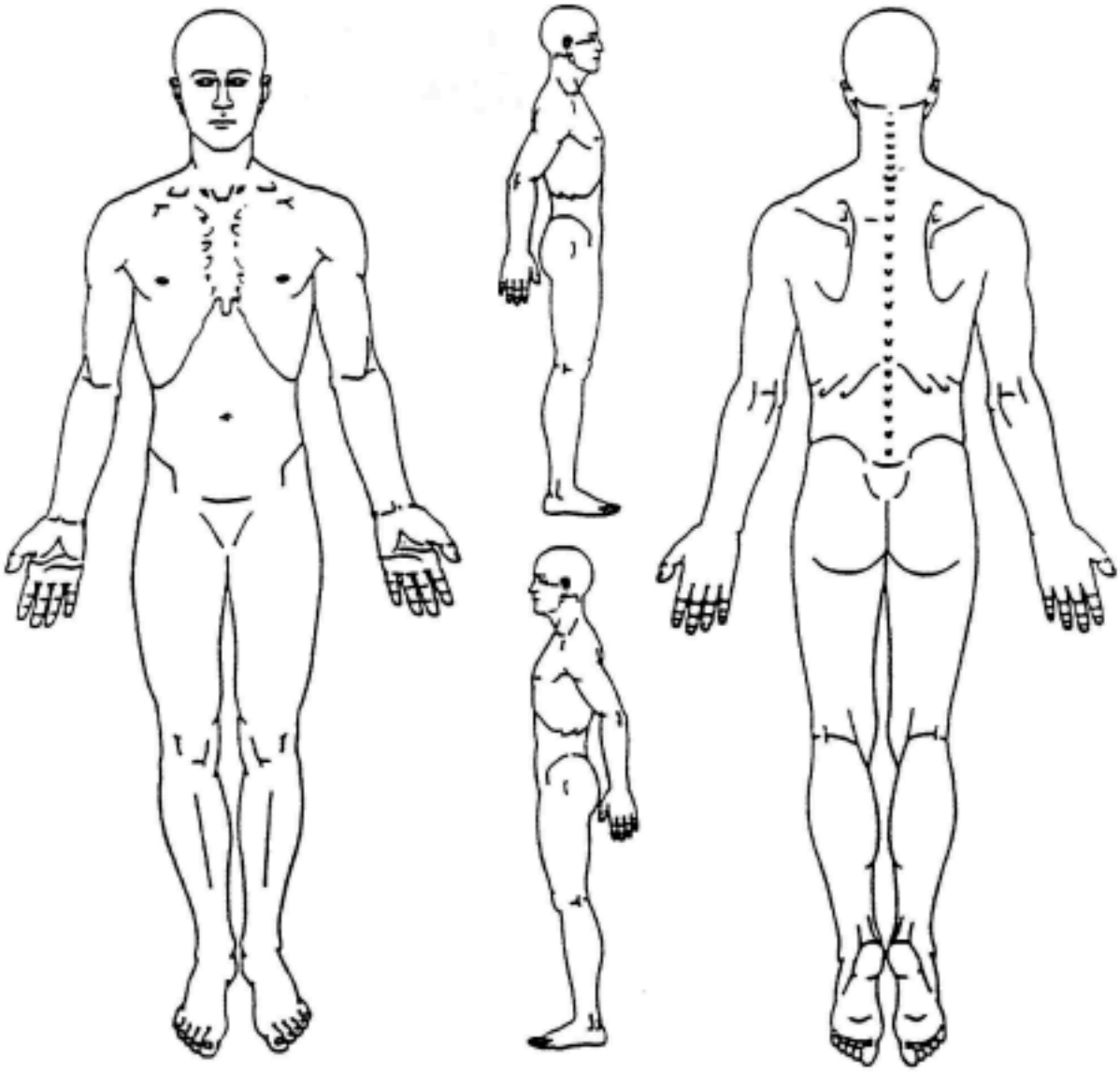
Comparative Pain Scale

None	0	No pain. Feeling perfectly normal.
Minor Does not interfere with most activities. Able to adapt to pain psychologically and with medication or devices such as cushion	1 Very Mild	Very light barely noticeable pain, like a mosquito bite or a poison ivy itch. You rarely think about the pain.
	2 Discomforting	Minor pain, like light pinching the fold of skin between thumb and first finger using fingernails.
	3 Tolerable	Very noticeable pain, like an accidental cut, a blow to the nose causing bleeding. Pain is not so strong that you cannot get used to it. Eventually most of the time you don't notice the pain. You have adapted to it.
Moderate Interferes with many activities. Requires lifestyle changes but patient remains independent. Unable to adapt to pain.	4 Distressing	Strong, deep pain, like an average toothache, or minor trauma to part of the body, such as stubbing your toe very hard. So strong you notice the pain all the time and cannot completely adapt. Note that the pain is initially piercing but becomes dull after that.
	5 Very Distressing	Strong, deep, piercing pain, such as a sprained ankle when you stand on it wrong, or mild back pain. Not only do you notice the pain all the time, you are now so preoccupied with managing it that your normal lifestyle is curtailed. Temporary personality disorders are frequent.
	6 Intense	Strong, deep, piercing pain so strong it seems to partially dominate your senses, causing you to think somewhat unclearly. At this point you begin to have trouble holding a job or maintaining normal social relationships. Comparable to a bad non-migraine headache, several bee stings, or bad back pain.
Severe Unable to engage in normal activities. Patient is disabled and unable to function independently	7 Very Intense	Same as 6 except the pain completely dominates your senses, causing you to think unclearly about half the tim. At this point you are effectively disabled and frequently cannot live alone. Comparable to an average migraine headache.
	8 Utterly Horrible	Pain is so intense you can no longer think clearly at all, and have often undergone several personality changes if the pain has been present for a long time. Suicide is frequntly contemplated and sometimes tried. Comparable to childbirth.
	9 Excruciating Unbearable	Pain so intense you cannot tolerate it and demand pain killers or surgery, no matter what the side effects or risk. If this doesnt work, suicide is frequent since there is no more joy in life whatsoever. Comparable to throat cancer.
	10 Unimaginable Unspeakable	Pain so intense you will go unconscious shortly. Most people have never experienced this level of pain. Those who have suffered a crushed hand, and lost consciousness as a result of the pain and not blood loss, have experienced level 10.

Anterior Right Side Posterior



Left Side

Please circle where you feel pain/discomfort. If pain is radiating, draw an arrow in the direction it is felt, from origin to end point.

Please mark (X) for all conditions that apply now. Put (P) for past conditions, and (F) for family history of illness.

Headaches, Migraines
Ringing in ears
Vision problems
Shortness of breath
Asthma
Chronic cough
Emphysema
Frequent colds
Bronchitis
Sinusitis
High blood pressure
Low blood pressure
Heart attack
Heart disease
Varicose veins
Blood clots
Stroke
Poor circulation
Pacemaker
Herpes

Hepatitis
Infectious skin conditions
Sensory loss/change
Shingles
Seizures
numbness/tingling
Epilepsy
Multiple sclerosis
Lyme disease
HIV/AIDS
Sciatica
Tuberculosis
Arthritis
Osteoporosis
Bursitis
Tendonitis
Jaw pain, TMJ
pins/plates/wires/artificial joints
Cancer
Diabetes
Fibromyalgia

Depression
Digestive disorder
Chronic fatigue syndrome
Anxiety
Psychiatric disorder
Hearing problems, deafness
Vertigo
Dizziness
Sprains
Strains
Tumors
Spinal column disorder
Rashes/athletes foot
Fungal infection
Sleep difficulty
Hernia
Birth control/IUD
Constipation
Diarrhea
Other medical conditions not listed

Diet

List what your daily meals look like:
Morning:

Afternoon:

Evening:

List what you drink throughout the day/estimated ounces:

List any type of snacks you normally consume:

List any other food/drink consumption outside of these categories if any:

Consent

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Massage Therapy 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. Because Massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that I reserve the right to terminate, or modify the session at any time I feel necessary. **This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session, with the possibility of law enforcement involvement, and I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. _____(Initials)**

Male and female genitalia and women's breasts will not be exposed or touched at any time. Draping will be used for your privacy and comfort. Our policy requires therapists to use draping with sheets/ blankets at all times during every massage session.

Please Initial: _____

Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

Signature of Client:_____ Date:_____

Signature of LMT:_____ Date:_____

Cancellation Policies

Out of respect for the therapist these are our policies for no-shows, late arrivals, and cancellations. **No-Shows**:

If you are not present for the first 15 minutes of your appointment (unless you've called ahead of time about being late), you will be considered a no-show, charged a percentage of the fee, and the time slot will become available for someone else.

A second account of no-call, no-show will result in your termination as a patient based on the circumstances.

Late Arrivals:

It is required that you show up to your appointment a minimum of 5-10 minutes early to account for time needed to take notes and get comfortable on the table. New patients will require 15-20 minutes to fill out intake forms unless they were completed before the scheduled appointment.

Late arrivals will still be charged for the full amount of time requested. It is to the discretion of the therapist to extend your time or not as there may be other appointments after yours. Depending on the circumstances, some late arrivals may be excused but if lateness becomes a habit, it will result in termination of future appointments.

Cancellations:

To cancel an appointment, 48 hours notice must be given. If you are able to fill your time slot with a new patient then you will not be charged for the missed appointment. If the time slot is not filled or only partially filled, then you will be charged a percentage of the fee for the time slot. Less than 24 hour notice will result in a 50% fee charge, which must be fulfilled before your next appointment.

-First cancellation will result in 25% fee charge

-Second cancellation will result in 50% fee charge

-Three or more cancellations will result in 100% fee charge

-More than three cancellations can result in termination of future appointments depending on the circumstances and to the discretion of the therapist.

Thank You, for your time and consideration of this practice. Please sign that you have read and understand the policies above.

Patient signature:_____ Date:_____

Client Initials:_____

Code of Ethics

In this setting we are committed to the highest qualities of professional health services. We are dedicated to honor, trust, attentiveness, and compassion towards our clients. That being said, there is an extensive list of our practice guidelines on the office of professions website under the topic of massage therapy.

Expectations

It is expected of the client/patient to maintain good hygiene and not use illegal drugs or alcohol before the session as this makes it unsafe for the client to receive massage. Client information is not shared with any members of the public or other healthcare providers unless the client releases the information in writing. A court of law may order the client's health-care records be released to the court as part of a legal proceeding. Therapists are obligated to report information about the abuse of a child, elderly person, or mentally or physically challenged person in the event that such information is related during the session. Therapists are obligated to report threats of self-harm, or threats that the client plans to harm another person, to authorities.

Patient signature:_____ Date:_____