



21351 Gentry Dr. #114
Sterling, VA 20166
(703) 982-0006

Patient Name:

LAST: _____ FIRST: _____ MI: _____ M: ___ F: ___

DOB: ___ / ___ / ___

ADDRESS: _____ CITY: _____ STATE _____ ZIP _____

PHONE NUMBER: _____ EMAIL: _____

How Did You Hear About Us?

Are You Vaccinated? Y ___ N ___

Emergency Contact:

LAST _____ FIRST _____ MI _____ M _____ F _____

RELATIONSHIP: _____ PHONE NUMBER: _____

Insurance Information:

Insurance Carrier _____ Insurance Plan _____

Phone Number _____ Policy Number _____

Group Number _____

Complete if patient is a minor:

Responsible Party Name: _____ Relationship: _____

Responsible Party Phone Number: _____

Patient Intake and Summary:

1. What are your major symptoms? _____

2. What does this prevent you from doing and enjoying? _____

3. How long has this problem been occurring? _____

4. Is the problem from an injury? _____

5. Please list all the major accidents or surgeries, including dates: _____

6. **Women only:** Are you pregnant or is there a possibility you may be pregnant? YES ___ NO ___

7. Have you had a professional massage before? YES ___ NO ___

8. Please circle your areas of concern:



9. Please list any allergies: _____

10. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage therapy session for you? _____

*****Draping will be used during the session-only the area being worked on will be uncovered. Informed written consent must be provided by parent or legal guardian for any client under age 17.**

HIPPA CONSENT AND FINANCIAL POLICY:

HIPPA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. By signing below the patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The practice may condition receipt of treatment upon the execution of this consent.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

COURTESY/NO-SHOW POLICY:

We are a busy practice and we book out a couple of weeks in advance, often with a waitlist. If you are unable to keep your scheduled appointment, as a courtesy, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

No show policy: If you do not show up to your appointment without notifying us, the first time will be a warning and after that, you will be charged \$75 or you will lose one session if on a Plan Of Care, for the time we were not able to fill when you were a no show.

Signature of Patient: _____ Date: _____

GENERAL LIABILITY RELEASE FORM:

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage 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 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 that I am aware of. I understand that massage therapists 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 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 any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

SIGNATURE OF CLIENT: _____ DATE: _____

SIGNATURE OF MASSAGE THERAPIST: _____ DATE: _____