AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

Therapeutic Massage Health Information Intake Form & Contract

Therapist:_____**Date:**_____
Location:_____**Tel:**_____

A. Client Information:

Full Name: _____□Male □Female □Infant □_____
Home Address:_____Tel:_____(Home)
_____ Tel: _____(cell)
Email Address: _____ Web:_____
Date of Birth: _____ Age: _____Social Security #_____
Occupation: _____Employer:_____Tel:_____
Emergency Contact: _____ Relationship:_____
Tel-1:_____ **Tel-2**:_____ Email: _____

B. Current Health Information: Please include Rx, pain-relievers, over-the-counter drugs (OTC) herbal remedies, Homeopathic or Natural Medicine, Vitamins/Minerals, etc.

Current Medications:	Past Medications:
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

C. Health History: Please list & explain: Include approximate dates & treatment received. Note if still under Primary Care's care for anything listed.

Surgeries:_____
_____
_____

Injuries:_____
_____
_____

Major Illnesses and/or disabilities:_____
_____
_____

Psychological or Mental Health:_____
_____

D. Current Conditions: Please check **ALL** that apply. Please feel free to comment – as necessary:

□ Anxiety_____
□ Auto-Immune Disorder_____
□ Arthritis_____
□ Backache_____
□ Bruise Easy_____
□ Cancer _____
□ Cardiovascular_____
□ Carpel Tunnel Syndrome_____
□ Chronic Fatigue Syndrome_____
□ Cystic Fibrosis_____
□ Depression_____
□ Dermatitis (Skin Problems)_____

□ Diabetes_____
□ Fibromyalgia_____
□ Headache & Migraine_____
□ Neck, Shoulder or Arm Pain_____
□ Numbness or Tingling_____
□ Osteoporosis_____
□ Pain_____
□ PTSD_____
□ Seizures_____
□ Sinus Problem_____
□ Sleep Disturbances_____
□ Spasms, Cramps_____
□ Spinal Problem_____
□ Stiff or Painful Joints_____
□ Varicose Veins_____
□ Weak or Sore Muscles_____
□ Other:_____
□ _____

E. Allergies:

□ Scents, Oils, Lotions:_____
□ Detergents, Fabric Softeners:_____
□ Other:_____

F. Activities of Daily Living: Please check any which are currently aggravated or limited:

□ Work	□ Running	□ Playing with Family
□ Computer Work	□ Bending	□ Recreational Sports
□ Driving	□ Lifting	□ Other:
□ Sitting	□ House Work	□ Other:
□ Standing	□ Self-Care	□ _____
□ Walking	□ Sleep	□ _____

Contract for Care: In signing, I the client, understand & agree that Massage Therapist work with the Healthcare Professionals, and based on his/her diagnosis, offer non-pharmacological treatment, under the guidance of, and in collaboration with my own medical doctor, or other healthcare provider(s). I further understand & agree that;

- I have obtained a 'Script' or a referral from my physician or healthcare provider for this medical massage.
- I have received a Copy of Privacy Rules & Regulations from the Massage Therapist.
- I have been told by the Therapist her/his Assessment & Treatment Plan, and I hereby Agree to the same.
- I understand that the Therapist has the right to refuse treatment if client/patient appears to be under the influence of drugs/alcohol or for other undisclosed reasons.
- I understand that the Therapists, as a rule, never touch genitals, females breast tissue or other areas clients expressly instructs therapist not to touch, before or during the therapeutic session.
- I understand that AMMN Affiliated Medical Massage Therapists are NOT trained to, and do NOT diagnose physical/mental illness or disease or prescribe medical treatments, spinal manipulations or pharmaceuticals.
- If necessary, I will provide her/him with my 'Consent' to obtain my health records & results of all diagnostics.
- I understand & agree that the Therapist may share my progress with my healthcare provider(s).

It is the client's responsibility to seek appropriate healthcare provider for diagnosis & treatment of any suspected medical problem and to inform the massage therapists of any existing or potential health conditions. In signing this contract, the client/parents/caregiver expressly gives her/his consent to the appropriate massage, as determined by the Therapist. The client, parent(s) and/or registered caregiver (**please circle**) expressly releases the Therapist, the AMMN, the Massage Organization and its administrators & staff, etc. of any liability whatsoever.

Signature of Client:_____Date:_____

Signature of Parents/Guardian/Caregivert_____Date:_____

Time started:_____Time finished:_____ Oil Used:_____ _____
Comments:_____
_____
Amount Paid/Billed: Insurance Co.
Signature of Therapist: