AMERICAN MEDICAL MASSAGE NETWORK

Health Information Intake Form & Contract

A. Client Information:

Full Name: _____ □ Male □ Female □
Home Address: _____Tel: _____(Home)
_____ Tel: _____(cell)
Email Address: _____ _____
Date of Birth: _____ Weight: _____ Social Security #_____
Occupation: _____ Employer: _____Tel: _____
Emergency Contact: _____ Relationship: _____
Cell Tel: _____ Email: _____ _____

B. 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: _____
***** Blood Pressure: (Systolic/Diastolic): _____Smoking: □ Yes □ No - Vaping: □ Yes □ No

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

Surgeries:_____
_____
_____

Injuries:_____
_____
_____

Have you had **COVID**? □ Yes □ No - Are you vaccinated: □ Yes □ No – **Monkey Pox**: □Yes □No

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_____
□ Weight Gain/Loss _____
□ 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 Therapy is for Pain Reduction, General wellness purposes, for stress reduction, and that the Massage Therapist;

- Has the right to refuse treatment if client appears to be under the influence of drugs/alcohol, high blood pressure or for other undisclosed reasons.
- Will never touch genitals, females breast tissue or other areas clients instructs therapist not to touch
- Is not trained to, and does NOT diagnose physical/mental illness or disease or prescribe medical treatments, spinal manipulations or pharmaceuticals.

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 or underline**) expressly releases the Therapist, her/his staff, American Medical Massage Network Organization (AMMN), the AAIE and all administrators & staff, etc. of any liability whatsoever.

Signature of Client: _____ Date: _____

Signature of Parents/Guardian/Caregiver: _____Date:_____

☐ I allow ☐ do not allow you to communicate with my healthcare provider & health insurer to keep them informed of this massage therapy treatment. We highly recommend that your physician/insurer be made aware of all treatments you are getting, including any OTC, Vitamins, etc. □ If you wish, we would be happy to send a report to ☐ your physician ☐ health insurance company ☐_____.

Name of your Physician: _____City/State: _____Tel:_____

Health Insurance Company: _____Policy #_____Expiry Date: ____

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Time started: _____Time finished: _____ Oil/Lubricants Used: _____ _____

Comments: _____

Date: _____ Amount Due/Paid:_____Name/Signature of Therapist:_____

- Health Insurance companies generally do not pay for massage, but we can try to negotiate for such coverage. We would be happy to adjust the reimbursement from your cost.

Click Button to SUBMIT