HANDS *on* HEALTH

Therapeutic and Medical Massage: Neuromuscular ▪ Myofascial ▪ Swedish ▪ Deep Tissue ▪ Sports ▪ Pregnancy ▪ Hot Stone ▪ Classes

Doing a fabulous job for the Triangle Community means a lot to us. By checking ALL that apply, we'll know how we're doing and whom to thank! What prompted you to schedule your first visit with Hands On Health?

___ My friend/family named _____
___ Referred by healthcare provider: (ie. Chiropractor, Acupuncturist, PT, other). Who?_____
_____
___ On-line: Circle: Google, Yelp, Bing, mobile search, other_____
____ Event (ie. health fair): What event? _____
____ Social Media: Facebook, Twitter, other: _____
____ Appointment was available when I wanted/needed
____ One of Hands On Health's massage therapists was recommended: What Therapist? _____
____ I heard about HOH from several sources

Let's stay connected: Follow tweets: *HandsOnHealthNC* | Join us on Facebook at H*andsOnHealth.Massage.Therapy*

Confidential Health Intake Form | Contact Information:

Your Name: _____ Mobile Phone: _____
Address: _____ Work Phone: _____
City/State: _____ Zip:_____ Home Phone: _____
Email: _____ ***Circle one:*** NO | Yes, join our e-newsletter

Circle one: What is your preferred method for reminders: phone call | email | text ***and my mobile carrier*** is with (circle one): Verizon | Sprint | AT&T | Other: _____

Occupation:_____ Employer/Industry: _____

Date of Birth: ___/___/___ Age: ___ Sex: M F Ht: ____ Wt: ____

Please check the following conditions that apply or have applied to you:

____ Arthritis	____ Headache	____ Neck pain	____ Herniated disc	____ Digestive disorders
____ Diabetes	____ Head Injury	____ Thoracic outlet	____ Heart problems	____ Herpes zoster/shingles
____ Numbness	____ Phlebitis	____ Fibromyalgia	____ Sinus problems	____ High blood pressure
____ Dizziness	____ Sciatica	____ Scoliosis	____ TMJ (Jaw) problems	____ Fatigue/insomnia
____ Cancer	____ Depression	____ Broken bone(s)	____ Varicose veins	____ Pregnancies: N Y
____ Epilepsy	____ Cramps/spasm	____ Low back pain	____ Bursitis/tendonitis	____ Osteoporosis

Describe and date any other medical conditions and/or ALL past surgeries, car accidents, head trauma:

_____
_____

Hrs cardiovascular/week? _____ Avg hrs prolonged sitting/day?_____ What sports/exercise do you participate?

_____
_____

List current medications (including those delivered by patch)/herbal supplements used and for what purpose:

_____
_____

My primary physician is _____ Phone: _____
Does HOH have permission to contact/consult with these healthcare providers *(only if necessary and with consent)*? Y N

Please list all other Health Care Providers on your wellness team *(physical therapist, orthopedist, neurologist, chiropractor, etc)*

_____
_____

Have you ever received massage or other integrated therapies for medically related purposes? (Check all that apply)
____ muscle pain relief ____ lumbar disc or SI joint conditions ____ cervical disc conditions _____ other

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Reason for your massage session today: ___medical massage (medical condition or injury), ___ muscle pain or soreness, ___ sports performance, ___ relaxation/health maintenance, ___ not sure. Details:_____
_____

Do you have a nut allergy? If yes, what? _____

About your comfort during the session – Please indicate the areas of the body that you ***DO NOT*** want massaged by the therapist without informing you ahead of time*:

____ Scalp	____ Chest	____ Buttocks region	____ Mid back
____ Face	____ Under arms	____ Sacrum	____ Upper back
____ Back/Side of neck	____ Side of rib cage	____ Hips	____ Upper Inner thigh
____ Shoulders	____ Abdominal region	____ Low back	____ Lower inner thigh

** Note: For therapeutic massage purposes mid buttocks region and pubic area are always draped for men and women; abdominal region and upper hip/buttocks is only undraped while the massage is being performed on that region and then re-draped immediately. In the cases of medical massage the following regions may receive treatments: the front of the neck, breast region (undraped with advanced written consent), pubic attachments, inner jaw, upper hamstrings and ligaments.*

Therapists reserve the right to decline, discontinue, or restrict services based on any information provided in this form and that may indicate that massage therapy would put the client's or therapist health at risk.

Please <u>read and initial</u> each item below to indicate that you have read, understand, and acknowledge being given informed consent:

_____ **STRICTLY ENFORCED.** ***I understand*** that Hands On Health requires me to pay in full for missed appointments or late cancellations. ***I agree to pay in full*** for the time that the therapist set aside for me, including those times I choose to end an appointment early or arrive late for any reason. To avoid being charged, ***I acknowledge*** that cancellation/rescheduling **notice must be given by 5pm the day before**. I agree to refrain from rescheduling/cancelling appointments/times when I book a same day appointment;

_____ I am aware that every appointment includes time for initial and post treatment consultation and is not solely time on the table; except in the cases where I seek massage for relaxation purposes, I understand that lengthier consultations are a part of the therapy session;

_____ I understand that payment is due when services are rendered unless payment arrangements have been made ahead of time;

_____ I am aware that due to the nature of therapeutic massage, techniques and tools may leave temporary discoloration of the skin. This temporary discoloration is a normal side effect of the therapy. Techniques that may temporarily discolor include but are not limited to deep friction massage, massage cupping, and gua sha.

_____ I understand that **massage practitioners do not diagnose** illness, disease, or any physical or mental disorder. I acknowledge that massage is not a substitute for medical treatment, and it is recommended I see a primary healthcare provider for that need;

_____ I understand that it is only fair to me and to my practitioner that **I speak up at any time during my session** if I have concerns or questions; my therapist and I have the right to end a session at any time. We recommend a call in advance of the next session should you have any concerns about a prior session.

_____ I acknowledge that I am aware of Hands On Health's **HIPAA obligations** regarding the disclosure of my health information by Hands On health to other healthcare professionals. I agree that I will ask for clarification if I do not understand these policies.

_____ I understand the Hands On Health provides therapeutic massage services only and that inappropriate actions or comments are not permitted at any time.

I have read and understand these policies and I agree to honor Hands On Health's Cancellation policy:

Signature (parent/guardian if under 18*) _____ Date _____

* Under age 16, we recommended that a parent/guardian remain with the child during the session until therapeutic relationship is established.