

Sarah Franklin Massage  
425-984-4200

8226 196<sup>th</sup> Ave NE  
Redmond, WA 98053

## Client Intake Form

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### Patient Information:

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Marital Status: Single Married

Emergency Contact/Relationship: \_\_\_\_\_

Contact's Phone: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

### Insurance Information:

Is your injury work related? Y N If so, L & I #: \_\_\_\_\_

Is your injury due to an auto accident? Y N If so, date of accident: \_\_\_\_\_

Please provide your auto insurance company name, claim #, and claim manager's name and phone number:

\_\_\_\_\_

If your treatment is to be billed to your health insurance:

Name of Insurance Co.: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

ID # with alpha prefix: \_\_\_\_\_ Group #: \_\_\_\_\_

**Medical Information:**

Are you currently under the care of another health care provider? Y N

Provider's Name: \_\_\_\_\_ Provider's Phone: \_\_\_\_\_

"I give my massage therapist permission to consult with my health care provider regarding my health and treatment."

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any medications or supplements you are currently taking: \_\_\_\_\_

Briefly describe your primary health concern(s) or complaint(s): \_\_\_\_\_

**Health History:**

Please check any of the following that apply to you. Use the back of the form for any explanation or to add further details.

**Musculo-Skeletal**

- Headaches
- Neck/Upper Back Pain
- Low Back/Hip Pain
- Arm or Leg Pain
- Weak or Sore Muscles
- Stiff or Painful Joints
- Tendonitis
- Sprain or Strain
- TMJ Dysfunction/Jaw Pain
- Spinal Problems
- Scoliosis
- Disk Problems
- Rheumatoid Arthritis
- Osteoarthritis
- Other:

**Circulatory & Respiratory**

- Heart Disease
- Blood Clots
- Stroke
- Lymphadema
- High/Low Blood Pressure
- Poor Circulation
- Varicose Veins
- Asthma
- Other:

**Skin & Allergies**

- Rashes
  - Athlete's Foot, Warts
  - Allergies to oil/scents
  - Allergies to detergent
  - Other:
- Digestive**
- Indigestion or Dysfunction
  - Diverticulitis
  - IBS
  - Crohn's Disease
  - Colitis
  - Bladder/Kidney Dysfunction
  - Abdominal Pain
  - Other:

**Nervous**

- Numbness, Tingling
- Dizziness, Confusion
- Sciatic Pain, Shooting Pain
- Head/Spine Injury
- Fatigue
- Sleep Disorders
- Other:

**Reproductive**

- Currently Pregnant
- Other:

**Other**

- Fibromyalgia
- Diabetes
- Depression
- Hearing impaired
- Visually impaired
- Cancer
- Thyroid Dysfunction
- Anxiety/Stress
- Surgeries:
- Infectious Condition:
- Exercise Regimen:
- Alcohol/Drug Use
- Nicotine Use

# of glasses of water per day:

Anything else I need to know?

## **Policies and Procedures:**

### Contract for Care:

I promise to participate fully as a member of my health care team. I will inform my health care team if, at any time, I feel my well-being is compromised. I promise to approach my treatment and care with a sense of positive intention.

### Consent for Care:

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that massage therapy is therapeutic and non-sexual in nature. I understand that massage therapists do NOT diagnose illness or disease and that massage therapy is NOT a substitute for medical examination or diagnosis. I also understand that massage therapists do not perform spinal manipulations. I affirm that I have completed the medical information and history forms to the best of my knowledge and will update my massage therapist on any changes to my health.

### Assignment of Benefits and Release of Medical Records:

I authorize my insurance company to make payments directly to the massage therapist in connection with my care. I authorize the release of my medical records to the insurance company for the purpose of processing my claims. My medical records will be kept confidential unless so directed by myself or unless it is required by law. My medical records will be kept for a minimum of three but no more than ten years after the date of my last visit. I have declined a copy of the HIPAA Privacy Regulations.

### Financial Responsibility:

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes partial payment, I am responsible for the balance.

- 24 hours notice is requested for all cancellations. **There will be a \$35 charge for cancellations that happen without 24 hours notice or for a "no show."**
- All payments will be accepted in the form of cash or check.

If you have any questions about these policies and procedures, please contact your massage therapist.

I have read, and understood, this agreement.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_