RANGE
PHYSICAL THERAPY + WELLNESS

# Client Intake Form - Therapeutic Massage

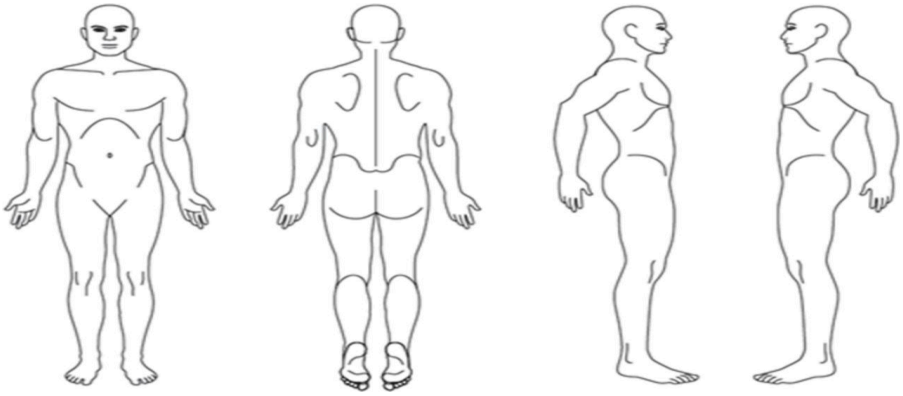
## Personal Information:

Name: _____ Date: _____ Date of Birth _____
Phone: _____ Email: _____
Address: _____
Occupation: _____ Emergency Contact: _____ Phone: _____

**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.**

1. Have you had a professional massage before? □Yes □No
   If yes, how often do you receive massage therapy?_____
2. Do you have any difficulty lying on your front, back, or side? □Yes □No
   If yes, please explain: _____
3. Do you have any allergies to oils, lotions, or ointments? □Yes □No
   If yes, please explain: _____
4. Do you have sensitive skin? □Yes □No
5. Are you wearing □contact lenses □dentures □a hearing aid?
6. Do you sit for long hours at a workstation, computer, or driving? □Yes □No
7. Do you perform any repetitive movement in your work, sports, or hobbies? □Yes □No
   If yes, please explain: _____
8. Do you experience stress in your work, family, or other aspects of your life? □Yes □No
   If yes, □Muscle tension □Anxiety □Insomnia □Irritability □Other_____
9. Is there a particular area of the body you are experiencing tension, pain, or discomfort? □Yes □No
   If yes, please explain: _____
10. Do you have any goals in mind for this massage session? □Yes □ No
    If yes, please explain: _____

**Circle any areas you would like the therapist to concentrate on during the session:**



Ph: 406.370.1377
Fax: 406.258.0645

945 Wyoming St Suite 135
Missoula, MT 59801

info@rangeptmontana.com
www.rangePTmontana.com

RANGE
PHYSICAL THERAPY + WELLNESS

## Medical History

11. Are you currently under medical supervision? □Yes □No
    If yes, please explain_____
12. Do you see a chiropractor? □Yes □No
    If yes, how often? _____
13. Are you currently taking any medication? □Yes □No
    If yes, please list: _____
    _____

14. Please check any of the conditions listed below that apply to you:

□ contagious skin condition
□ open sores or wounds
□ easy bruising
□ osteoporosis
□ epilepsy or seizure
□ fracture or suspected fracture
□ deceased sensation
□ cancer
□ heart condition / pacemaker
□ high or low blood pressure
□ pregnancy If yes, how many months?_____

□swelling / joint pain
□deep vein thrombosis/blood clots
□varicose and/or spider veins
□recent accident or injury
□dizziness / vertigo
□headaches/migraines
□injury to head
□surgeries
□circulatory disorder
□osteoarthritis / rheumatoid arthritis

□infection
□fibromyalgia
□allergies/sensitivities
□mental condition
□ depression/anxiety
□ night pain
□ diabetes or hypo/hyperglycemia
□neurological condition (Parkinson's, MS, etc)

Please explain any condition you have marked above _____
_____

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

Ph: 406.370.1377
Fax: 406.258.0645
945 Wyoming St Suite 135
Missoula, MT 59801
info@rangeptmontana.com
www.rangePTmontana.com

RANGE
PHYSICAL THERAPY + WELLNESS

## Acknowledgement of Responsibilities

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

I,_____(print name) understand that all the massage sessions I receive are therapeutic in nature and are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain, discomfort, or draping issues during this session, I will immediately inform the therapist so that the pressure and/or strokes or draping may be adjusted to my level of comfort. The therapist has provided me with the information on the Massage Cupping Body technique. If I choose to experience this therapy in my session, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of skin discoloration, or "cup kiss," appearing as tissue is released. I am aware that a "cup kiss" is not a bruise and it will dissipate within a few hours to a few days. I further understand that a 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 spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. Because a massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the 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 Range Physical Therapy & Wellness PLLC's (Range PT) or the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and possibly refusal of future sessions, and I will be liable for payment of the scheduled appointment.

Cancellation / No-Show Policy: If you are unable to keep your appointment **you must provide Range PT at least 24 hours advance written notice by email to info@rangePTmontana.com.** I accept that my massage session begins at the scheduled time, and should I arrive late, it will be at the expense of the time allocated for the session. I am aware that appointments may be rescheduled or canceled up to 24-hours prior to the scheduled session time with no charge. However, should I reschedule or cancel with less than a 24-hour notice I will be charged at full price for the session. I understand that if I do not show up for a scheduled appointment without a 24-hour notification that I shall also be charged for the full price of the session.

## HIPAA Acknowledgement
## Patient Consent of Receiving "Notice of Privacy Practices"

I authorize release of protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) and allow for electronic/verbal/written communication without my physical presence between Range PT licensed massage therapists and with other professional employees, as well as Range PT's independent contractors who work with Range PT in providing service to the patient/customer

**By signing below, I agree to all of the information outlined above and payment requirements outlined above giving Range Physical Therapy & Wellness permission to charge my current credit / debit card on file:**

| _____ | _____ | _____ |
|---|---|---|
| Client or Guardian, Printed Name | Signature | Date |

Ph: 406.370.1377
Fax: 406.258.0645
945 Wyoming St Suite 135
Missoula, MT 59801
info@rangeptmontana.com
www.rangePTmontana.com