

ADDRESS: 7040 Carroll Ave, #3 Takoma Park, MD | 20912

Client Intake and Medical History Disclosure Form (Please write legibly)

Name:	Age/DOB:		
Address:			
City:	State:	Zip:	
Cell phone:	Alterna	te phone:	
Email:		erred byor how did you r about me:	
Occupation:	Fo	orm of contact for	
Emergency Contact (name):		(phone):	
What are your goals for treatment?			
What areas of the body or conditions are you		ring care for:	
Have you ever been treated for this before?: _			
If so, when and type of treatment received for			
Have you recently had an injury, surgery, or an		mation?	
List all past surgeries and year(s) they occurre	ed:		
List past incidences (i.e. bone break, sprain, st (to the best of your recollection):			
Do you exercise regularly and/or participate in	n sports?	Describe:	

Please circle any/all illn	esses/conditions you've	either had in the past or cu	rrently have:		
Musculoskeletal	Respiratory	Skin	Other		
Bone or joint disease	Breathing	Allergies, specify:	Diabetes		
Tendonitis/Bursitis	Difficulty/Asthma	Rashes	Epilepsy/Seizures		
Arthritis	Emphysema	Cosmetic Surgery	HIV/AIDS		
Gout	Allergies, specify:	Athlete's Foot	Tinnitus		
Jaw Pain (TMJ)	Sinus Problems		Dizziness		
Lupus		Digestive	Vertigo		
Spinal Problems	Nervous System	Irritable Bowel Syndrome			
Osteoporosis	Shingles	Bladder/Kidney Ailment	Migraines		
Osteopenia	Numbness/Tingling	Colitis	Hepatitis/Liver Disease		
•	Pinched Nerve	Crohn's Disease	1		
Circulatory	Chronic Pain	Ulcers			
Heart Condition	Paralysis		Any other medical		
Phlebitis/Varicose Veins	Multiple Sclerosis	Psychological	condition(s) not		
Blood Clots	Parkinson's Disease	Anxiety/Stress Syndrome	listed:		
High Blood Pressure	Fibromyalgia	Depression			
Low Blood Pressure	, ,	•			
Lymphedema	Reproductive	Cancer			
Thrombosis/Embolism	Pregnant, stage	Type:			
		-			
	Ovarian/Menstrual	Year:			
	Problems				
	Prostate	Status:			
therapy practice; meaning	& Therapeutic Massage, ng we require payment fi	, LLC is a fee-for-service m	service. Body Mind		
Spirit MFR does not participate with any health insurance companies (i.e. Aetna, Blue Cross Blue Shield) or other reimbursement services (i.e. Medicare, Medicaid, Worker's Compensation, Lawsuit					
		who wish to submit docum			
their insurance providers or other reimbursement services, Body Mind Spirit MFR can provide proof					
of payment and services in the form of a "Superbill." A Superbill for Massage Therapy (MT) or					
Myofascial Release (MFR) services provides your insurance company with the information for					
potential massage therapy coverage reimbursement, but does not guarantee you will be reimbursed					
nor will it include a diagnosis code. It is the patient's responsibility to research if they will receive					
reimbursement from the insurance company. Please specify if you would like a Superbill emailed.					
Y/N Email:					
Client Agreement					
Chom rigi coment					
It is my choice to receive massage thereny/myofoscial release (MED) I am evvers of the honefite and					
It is my choice to receive massage therapy/myofascial release (MFR) I am aware of the benefits and					
risks of massage/MFR and give my consent for massage/MFR. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I					
acknowledge that massage therapy/MFR is not a substitute for medical care, medical examination or					

diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner

List all prescription medications you are presently taking & reason for medication:

of any changes in my health status.

Please mark the body diagrams with the following letters to indicate what you have been recently experiencing: P = Pain; T = Tightness; N = Numbness/Tingling; W = Weakness.

