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**ADDRESS:**  
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## **Client Intake and Medical History Disclosure Form**

(Please write legibly)

Name: \_\_\_\_\_ Age/DOB: \_\_\_\_\_

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

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

Cell phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_  
Referred by...or how did you

Email: \_\_\_\_\_ hear about me: \_\_\_\_\_

Occupation: \_\_\_\_\_ Form of contact for  
appointment reminders?: \_\_\_\_\_

Emergency Contact (name): \_\_\_\_\_ (phone): \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_

What areas of the body or conditions are you currently seeking care for:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated for this before?: \_\_\_\_\_

If so, when and type of treatment received for this:  
\_\_\_\_\_  
\_\_\_\_\_

Have you recently had an injury, surgery, or areas of inflammation?  
\_\_\_\_\_  
\_\_\_\_\_

List all past surgeries and year(s) they occurred:  
\_\_\_\_\_  
\_\_\_\_\_

List past incidences (i.e. bone break, sprain, strain; car or bike accident, etc.) and year(s) they occurred  
(to the best of your recollection):  
\_\_\_\_\_  
\_\_\_\_\_

Do you exercise regularly and/or participate in sports? \_\_\_\_\_ Describe: \_\_\_\_\_  
\_\_\_\_\_

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

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Please circle any/all illnesses/conditions you've either had in the past **or** currently have:

<b>Musculoskeletal</b>	<b>Respiratory</b>	<b>Skin</b>	<b>Other</b>
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			Vertigo
Spinal Problems	<b>Nervous System</b>	<b>Digestive</b>	Headaches
Osteoporosis	Shingles	Irritable Bowel Syndrome	Migraines
Osteopenia	Numbness/Tingling	Bladder/Kidney Ailment	Hepatitis/Liver Disease
	Pinched Nerve	Colitis	
<b>Circulatory</b>	Chronic Pain	Crohn's Disease	
Heart Condition	Paralysis	Ulcers	<b>Any other medical condition(s) not listed:</b> _____
Phlebitis/Varicose Veins	Multiple Sclerosis		
Blood Clots	Parkinson's Disease		
High Blood Pressure	Fibromyalgia		
Low Blood Pressure			
Lymphedema	<b>Reproductive</b>	<b>Cancer</b>	
Thrombosis/Embolism	Pregnant, stage	Type: _____	
	Ovarian/Menstrual Problems	Year: _____	
	Prostate	Status: _____	

### Document for Reimbursement

Body Mind Spirit MFR & Therapeutic Massage, LLC is a fee-for-service myofascial and massage therapy practice; meaning we require payment from the client at the time of 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 settlement cases, car accident cases). For clients who wish to submit documents and/or receipts to 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. 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 to you.

Y/N. Email: \_\_\_\_\_

### Client Agreement

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 of any changes in my health status.

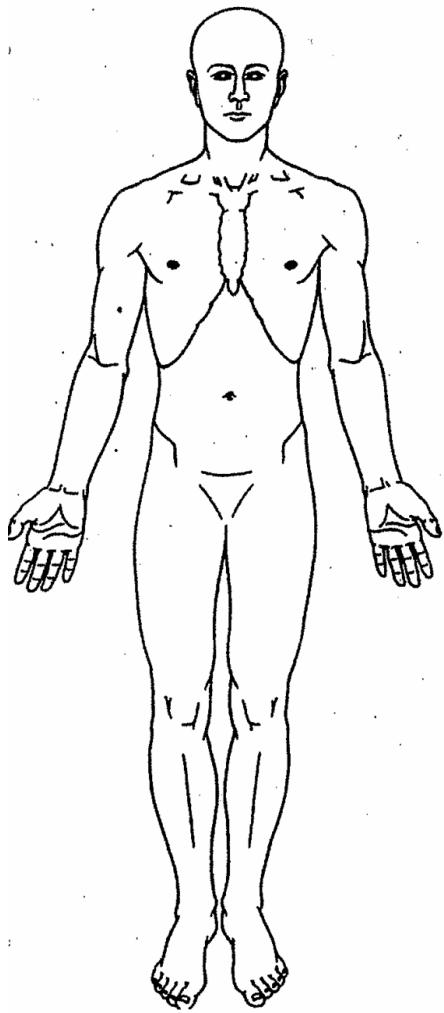
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Signature (Client/Guardian or Parent if client under 18 years old)

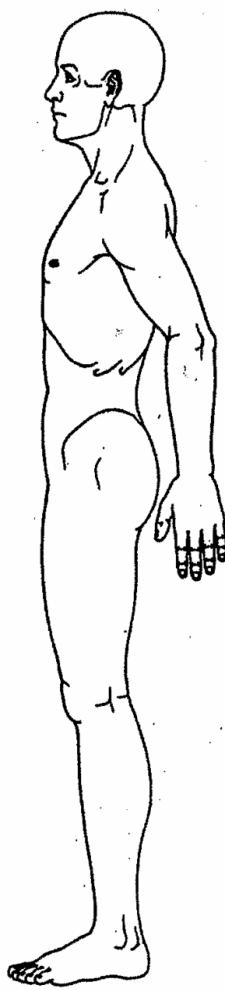
Date

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.

Right/Left



Left



Left/Right

