ejacobsmassage@gmail.com
ph: 202.643.9757

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

BODY MIND SPIRIT
MFR
& Therapeutic Massage

Client Intake and Medical History Disclosure Form

(Please write legibly)

Name:_____ Age/DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell phone:_____ Alternate phone:_____

Email:_____ Referred by...or how did you 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: _____
_____

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

Musculoskeletal
Bone or joint disease
Tendonitis/Bursitis
Arthritis
Gout
Jaw Pain (TMJ)
Lupus
Spinal Problems
Osteoporosis
Osteopenia

Circulatory
Heart Condition
Phlebitis/Varicose Veins
Blood Clots
High Blood Pressure
Low Blood Pressure
Lymphedema
Thrombosis/Embolism

Respiratory
Breathing Difficulty/Asthma
Emphysema
Allergies, specify:
Sinus Problems

Nervous System
Shingles
Numbness/Tingling
Pinched Nerve
Chronic Pain
Paralysis
Multiple Sclerosis
Parkinson's Disease
Fibromyalgia

Reproductive
Pregnant, stage _____
Ovarian/Menstrual Problems
Prostate

Skin
Allergies, specify:
Rashes
Cosmetic Surgery
Athlete's Foot

Digestive
Irritable Bowel Syndrome
Bladder/Kidney Ailment
Colitis
Crohn's Disease
Ulcers

Psychological
Anxiety/Stress Syndrome
Depression

Cancer
Type: _____
Year:_____
Status:_____

Other
Diabetes
Epilepsy/Seizures
HIV/AIDS
Tinnitus
Dizziness
Vertigo
Headaches
Migraines
Hepatitis/Liver Disease

Any other medical condition(s) not listed: _____
_____
_____
_____

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.

_____

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**