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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: _____

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 problem before?: _____

If so, when and type of treatment received for this problem: _____

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	Respiratory Breathing Difficulty/Asthma Emphysema Allergies, specify: Sinus Problems	Skin Allergies, specify: Rashes Cosmetic Surgery Athlete's Foot	Other Cancer/Tumors Diabetes Epilepsy/Seizures HIV/AIDS Tinnitus Dizziness/Vertigo Headaches/Migraines Hepatitis/Liver Disease
Circulatory Heart Condition Phlebitis/Varicose Veins Blood Clots High/Low Blood Pressure Lymphedema Thrombosis/Embolism	Nervous System Shingles Numbness/Tingling Pinched Nerve Chronic Pain Paralysis Multiple Sclerosis Parkinson's Disease Fibromyalgia	Digestive Irritable Bowel Syndrome Bladder/Kidney Ailment Colitis Crohn's Disease Ulcers	Any other medical condition(s) not listed: _____ _____ _____
	Reproductive Pregnant, stage _____ Ovarian/Menstrual Problems Prostate	Cancer Type: _____ _____ Year: _____ 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: _____

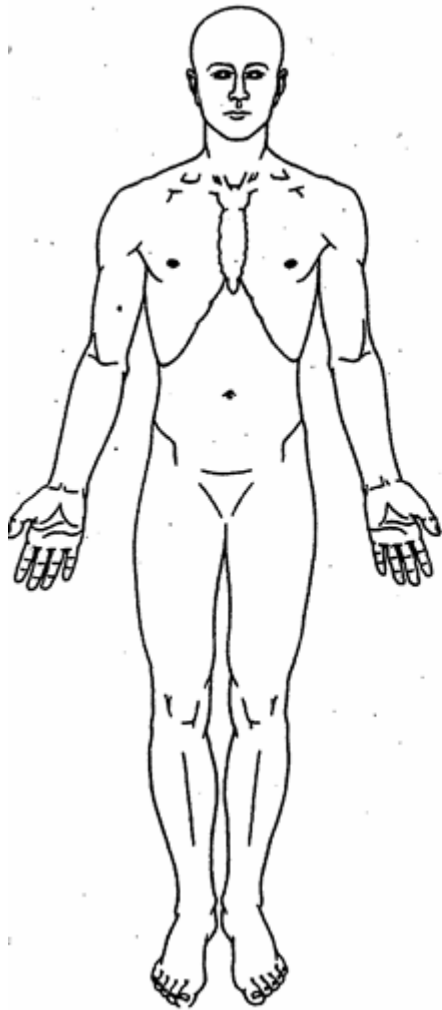
Client Agreement

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.

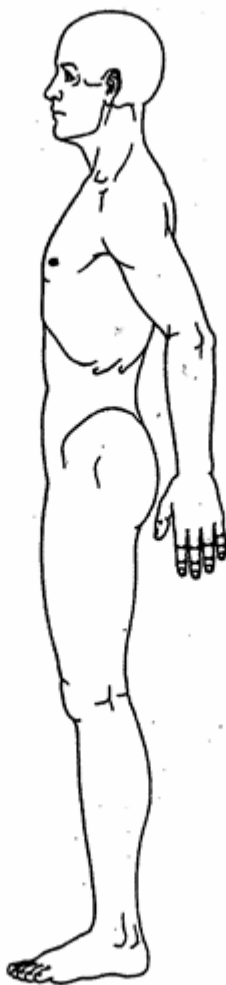
Signature (Client/Guardian or Parent if client under 18 years old) **Date**

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

