Confidential Case History

Marcia Vahila • Massage Therapy
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Name_____Today'sDate_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work or cell phone_____

E mail_____

Date of Birth_____Occupation_____

Referred by_____Have you had massage before?____

In case of emergency contact_____ Phone _____

Reason for Visit

Present symptoms/Major concerns_____

How long have you had this condition?_____

What was the initial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Has there been a medical diagnosis?_____ When?_____

Name of the doctor who gave the diagnosis_____

Are you currently receiving treatment for this condition?___ Yes ___ No

If yes, please describe your treatment_____

Medical History

Please list previous conditions for which you were treated_____

List any conditions for which you are currently being treated_____

Please list any medications you are taking_____

Please list any medical implants (pacemaker, joint replacements, etc.)_____

_____

List previous surgeries_____

Describe any significant traumas (car accidents, falls, etc.)_____

List any allergies

_____

(Note: we may use lubricants that contain peanut, soy or other nut, seed or vegetable oils, essential oils of plants such as lavender, pine, etc.)

Lifestyle

Do you take nutritional supplements? ___Yes___No Please list them_____

Do you consume:___ coffee ___ tea ___ soft drinks ___ alcohol ___ tobacco

Do you exercise? ___ No ___ Yes If so, please describe:_____

_____

List major areas of stress in your life_____

Consent to Treatment

By signing below, I voluntarily consent to be treated with massage by Marcia Vahila, Licensed Massage Therapist.

Massage therapy: I understand that Massage therapy involves the manipulation of the body through manual techniques. I am aware that certain side effects may result. These include, but are not limited to: bruising, and the possible aggravation of symptoms.

Notice of Privacy Practices

Your personal health information (PHI) will be used to provide you with treatment and for payment information. It will be disclosed to others only if you have given a written consent, if there is a threat to you or others, or it is required by law. You have a right to inspect your PHI. You may request an amendment to your PHI if there is an error or if it is incomplete. I acknowledge that I may request a copy of the Informed Consent and Notice of Privacy Practices.

I affirm that all information provided on this intake form is correct and assume any and all responsibility for incorrect or withheld information. I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask questions about the benefits and risks of treatment. I give my permission and consent to treatment. This permission is to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Patient Signature: _____Date: _____