NeuroMuscular @
NORTH TEXAS INSTITUTE OF NEUROLOGY AND HEADACHE

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MEDICAL NEUROMUSCULAR THERAPY

CLIENT INTAKE FORM

PERSONAL INFORMATION:

Name_____

Home Phone: _____ Cell Phone: _____

Address: _____

City/State/Zip: _____

Email: _____ Date of Birth: _____

Occupation: _____

Emergency Contact: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain: _____

   _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain: _____

   _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?

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6. Do you sit for long periods at a workstation, computer, or driving? Yes No

If yes, please explain: _____

_____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please explain: _____

_____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other

If other please list:_____

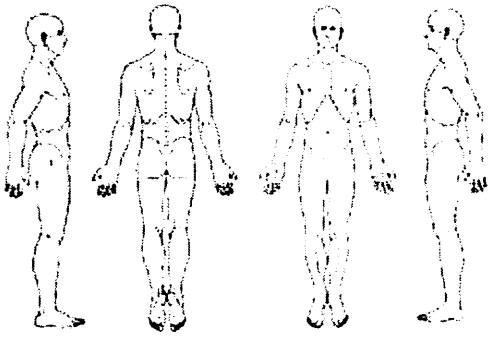
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify? _____

_____

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session



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10. Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain: _____

_____

11. Do you currently see a Chiropractor? Yes No

Please check any condition listed below that applies to you:

( ) contagious skin condition ( ) phlebitis ( ) open sores or wounds ( ) deep vein thrombosis/blood clots ( ) easy bruising ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis ( ) recent accident or injury ( ) osteoporosis ( ) recent fracture ( ) epilepsy ( ) recent surgery ( ) headaches/migraines ( ) artificial joint ( ) cancer ( ) sprains/strains ( ) diabetes ( ) current fever ( ) decreased sensation ( ) swollen glands ( ) back/neck problems ( ) allergies/sensitivity ( ) fibromyalgia ( ) heart condition ( ) TMJ ( ) high or low blood pressure ( ) carpal tunnel syndrome ( ) circulatory disorder ( ) tennis elbow ( ) varicose veins ( ) pregnancy If yes, how many months? ( ) atherosclerosis. Please explain any condition that you have marked above_____

12. Is there anything else about your health that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the session.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose or relaxation and the relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agreed to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client: _____ Date _____

Signature of Massage Therapist: _____ Date _____

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Medical Massage/Acupuncture Therapy Policy

We are now offering massage therapy for our patients. Medical massage therapy has been found to help alleviate many medical conditions. However, some insurance companies will not cover these services under the medical policy, or they may affect the physical therapy benefits. Due to these circumstances, we can provide the service without filing a claim to your insurance company. The fee for this standard service is $50.

We are also now offering the option to bill your insurance for medical massage therapy. Depending on what insurance provider you have, we may have the option to file claims for this service. If you chose to file your insurance, we must charge you the out of pocket cost they apply. If your insurance provider does not cover these services, we can bill as an office visit. The only exception to this is if your insurance provider does not cover these services and you have an after-hours appointment, where there is not a healthcare provider in the office, you will be considered a cash pay patient with a charge of $50. You may choose to cash pay a fee of $50, but your insurance can not be filed.

If you are a cash pay patient and have a health saving account (HSA), or a health reimbursement account (HRA), these services are considered a qualifying expense and you may use these services for reimbursement. Please notify the front office staff if you require a detailed receipt provided to you.

I _____ (Patient's Name), understand if I am a cash pay massage patient that I will be responsible for the full amount of my services today, prior to the service being rendered, and that reimbursement will not be received from my insurance company. The only exception is if the appointment is after hours, in which case I will receive a bill. If I am allowing my insurance to be billed, I understand that no charges will be collected today, that my office visit will be billed to my insurance provider, and that I may be billed my out of pocket costs depending on my insurance benefits.

I understand that should I fail to show for a confirmed appointment, or cancel an appointment within 24 hours, I will be charged a fee ($25 for massage and $150 for acupuncture) that must be paid before I can reschedule the missed appointment. I also understand that if I fail to show for a confirmed appointment, or cancel an appointment within 24 hours, NTINH reserves the right to deny scheduling any future medical massage/acupuncture therapy sessions.

Patient Signature _____ Date _____