312 Campbell St
Bisbee, AZ 85603-1511
(520) 432-5139
nicknight@cableone.net

Warm Hands Therapeutics

Client Intake Form

Contact Information:

Name: _____ DOB: _____
Address: _____
_____
Telephone: (W): _____ ext: _____
(H): _____ Cell: _____
(Fax): _____ Email: _____
Emergency Contact: Name: _____
Telephone: (W): _____ ext: _____
(H): _____ Cell: _____
Relationship: _____
Occupation/Employer: _____
Address: _____
_____
Telephone: _____

Medical Information:

Please answer all questions as specifically as possible, supplying dates where appropriate.

Primary Problem (including date of onset and cause, if known): _____
_____
_____
Secondary Problem(s): _____
_____
_____
Referral Source: _____

Primary Care Provider: _____
Telephone: (W): _____ ext: _____
(Fax): _____Mobile: _____
Address: _____
_____

Remember, if it's starting to stick,
its time to call Nick.

Permission to consult with Primary Care Provider?
Please initial if yes **Y** _____ **N**

Previous Surgeries (please include dates): _____

_____

_____

Major Illnesses or Accidents (please include dates): _____

_____

_____

Are you currently seeing a Medical Practitioner? (If yes, please explain): _____

_____

_____

Please list all current medications: _____

_____

_____

Massage History/Treatment Information:

Y N Have you ever received a professional massage?
How frequently do you receive massage? _____
Date of last massage: _____

Y N Are you wearing contact lenses? If yes, please circle: Hard Soft

Y N Are you pregnant? If so, what stage? _____

Y N Do you have a heart condition? _____

_____

Y N Do you have any varicose veins? Blood clots? Any other circulatory problems? _____

_____

Y N Do you have any kidney problems? _____

_____

Y N Do you have any nervous system problems? _____

_____

Y N Do you wear dentures?

Y N Are you wearing them now?

Y N Do you wear hearing aides?

Y N Do you have, or have you ever had cancer? _____

_____

Y N Are you experiencing any sleep disorders at this time? _____

_____

Y N Do you have any diabetes? If yes, how is it controlled? _____

_____

Y N Do you have high or low blood pressure? If yes, please circle: High Low
How is it controlled? _____

Y N Do you have any skin problems or allergies? _____

_____

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Y N Do you currently have an infectious or contagious disease? _____
_____

Y N Do you have any arthritis? If yes, circle which type: Osteo- Rheumatoid
Where is it located? _____

Y N Do you have any spinal problems? If yes, please describe: _____
_____

Y N Do you have any needs which require special attention? If yes, please
Specify: _____
_____

Y N Do you have any other medical condition that I should be aware of before
you receive massage? _____
_____

Y N Do you want specific results from your massage? If yes, please describe:
_____
_____

I understand that massage therapists do not diagnose illness, disease, or other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals, or perform spinal thrust manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical aliment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

It is my choice to receive massage therapy. I realize that the treatment being given is for the well-being of my body and mind. This includes stress-reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my massage therapist any time that I feel like my well-being is being compromised. This treatment is non-sexual; sexual behavior on the part of the client during the treatment is inappropriate and will result in the immediate termination of the treatment, for which payment is still due.

I have read and agree with the policies and procedures set forth in Warm Hands Therapeutics' Protected Health Information Statement of Privacy (HIPPA form, on green sheet).

Signature: _____ Date: _____

If this is to be insurance claim, please provide the following information:

Do you have a prescription for treatment? **Y N**
(If yes, please provide me with a copy).

Social Security #: _____

Date of Injury: _____

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