VEGA Massage

CONFIDENTIAL INTAKE FORM (Please complete form in its entirety provide to your therapist in advance of appt)

Date: _____

Patient's Name: _____
First **Middle Initial** **Last**

Address: _____
Street **City** **State** **Zip**

Date of Birth: ___/___/____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Phone Number: (_____) _____ ☐ Employed ☐ FT Student ☐ PT Student

Email Address: _____ Occupation: _____

Name of Referring Provider: _____ Employer: _____

Personal Injury Protection Insurance Information ☐ Yes ☐ No**,** I prefer to pay privately in full today.

_____(Initials) Yes, please bill my insurance directly. As a courtesy to you, we will bill your private insurance carrier. You agree to give consent to Nikki Vega LMT and Vega Massage to release protected health information for the purpose of treatment, payment or continuity of care. We will accept your insurance company's allowable reimbursement. All insurance deductibles are due at the time of service in accordance with the agreed upon contract by you and your insurance company. If your insurance claim is denied for any reason, you may be responsible for full payment. We are happy to help you to navigate insurance reimbursement and procedures, but will not become involved in disputes between you and your insurance carrier.

☐ **Workers Compensation** ☐ **Motor Vehicle Accident** *(Please enter the info for the insurance company covering your claim)*

Insurance Company Name: _____ Name of Adjuster: _____

Employer/Policy holder Name: _____ Phone # of Adjuster: _____

Birth date of Policy holder: _____ PIP Claim #: _____

State where your accident occurred: _____ Is this a 3rd party Insurance Carrier?: _____

Date of Loss/Accident: _____ If so, name of your own insurance: _____

Were you found to be "at fault?" _____

Any other details about billing? _____

****

Your business is valued and your cooperation is appreciated. We are making a commitment to serve you by guaranteeing your appointment time. Late arrivals may not receive the full session time allotted for the service booked. Patients who reserve an appointment and fail to cancel 24 hours in advance will be assessed a $50 fee, which cannot be billed to your Personal Injury Protection coverage.

Signature: _____ Date: _____

Name: _____ *Date of Birth:* _____

1. How were you hit? (i.e. direction body thrown/shifted, were you stopped or moving, where was arm/leg placement, seatbelt on, etc.) _____

   _____
2. Have you been to see a medical provider since the accident? If so, full name of provider(s): _____

   _____
3. Are you experiencing headaches after the accident? _____ Do you have a headache now?_____
4. Are you experiencing sleep disturbance since the injury?_____
5. What areas of your life are most impacted from pain and/or discomfort? _____
6. Any problems doing your job or normal activities of daily living?_____
7. Have you had any prior accidents, injuries or surgeries to the affected area?_____
8. How are you feeling today? (Emotionally, physically…) _____
9. Aside from the accident, have you had any major injuries, surgeries, or broken bones in the past 2 years? *Explain.*_____
10. Have you ever received a professional massage before? _____
11. What level of pressure do you feel you can tolerate? ☐ Light ☐ Medium ☐ Deep
12. Do you take any prescription or over-the counter medications? ☐ Yes, listed below ☐ No

    _____
13. Are you allergic to any oils, lotions, scents? _____

MEDICAL HISTORY - *Please check all that apply about your personal medical condition(s):*

☐ AIDS/HIV	☐ Depression	☐ Infectious condition
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis
☐ Allergies	☐ Fainting	☐ Neuropathy/nerve problems
☐ Anxiety	☐ Fever	☐ Numbness
☐ Asthma	☐ Fibromyalgia	☐ Osteoporosis
☐ Back Pain	☐ Headaches	☐ Pace Maker
☐ Blood Clots	☐ Heart Condition	☐ Pregnant
☐ Bursitis	☐ Hepatitis	☐ Sleep Problems
☐ Cancer	☐ Herniated Disk	☐ Shingles
☐ Carpal Tunnel	☐ Hypertension	☐ Skin Condition or rash
☐ Chronic Fatigue	☐ Hypoglycemic	☐ Tendonitis
☐ Diabetes	☐ Hypo/Hyper Thyroid	☐ TMJ
☐ Dizziness	☐ Inflammation	☐ Other (s) _____

I will immediately inform the practitioner of any pain or discomfort should it arise during the session so that it may be adjusted accordingly. I understand that massage is not a substitute for an examination, diagnosis or treatment of disease/injuries and that I should see a physician or other qualified specialist to address medical conditions I may have. Because massage should not be performed under certain medical conditions, I affirm that I have completed this medical history to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I neglect to disclose medical information that may contraindicate treatment.

Client Signature: _____ Date: _____

Parent/Guardian Signature for minor child or dependent _____ Date: _____