

CSRA NEUROMUSCULAR MASSAGE LLC

CLIENT INTAKE & HEALTH HISTORY FORM

CONFIDENTIAL – PROTECTED HEALTH INFORMATION (HIPAA)

This intake form is protected under HIPAA. The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164 (HHS.gov).

CLIENT INFORMATION

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number(s): _____

Email Address: _____

Referred By: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number: _____

COMMUNICATION PREFERENCE

May we call or text your appointment reminders?

Yes No

REQUESTED MASSAGE TECHNIQUE ~INDICATE ON THE ANATOMICAL CHART YOUR AREAS OF CONCENTRATION~CIRCLING THE ENTIRE BODY MEANS YOU WANT THE FULL SESSION TO COVER YOUR ENTIRE BODY INSTEAD OF A CONCENTRATED AREA.

(Please check all that apply)

- Therapeutic / Medical Massage
- Sports Massage
- Swedish / Relaxation Massage
- Prenatal Massage **If yes, what trimester?** _____



MEDICATIONS & SUPPLEMENTS

Please list all current medications, vitamins, supplements, or topical medications and indicate if you currently use or have any of the following, as they may be **contraindicated** with certain therapeutic modalities:

- Fentanyl patches
- Blood thinners
- Nitroglycerin tablets
- Albuterol inhalers
- Muscle relaxants
- Chemotherapy or radiation therapy
- Implanted medical devices (e.g., muscle stimulators, pacemakers, or sleep apnea implants such as *Inspire*)

Note: Some durable medical devices used in treatment may require implanted devices to be turned off. Please discuss this with your therapist prior to your session.

PHYSICIAN CARE

Are you currently under a physician's care? Yes No

If yes, physician's name: _____

Condition(s) being treated:

ALLERGIES OR SENSITIVITIES

Please list any allergies (including oils, lotions, fragrances, or environmental sensitivities):

IMPORTANT NOTICE & SCOPE OF PRACTICE

CSRA Neuromuscular Massage is an **in-home healthcare practice**.

The therapist is internationally certified with diverse credentials in Medical Massage, Fitness, Nutrition, and Self-Management.

- I am **not a physician** and do not diagnose medical conditions.
- I am authorized within my scope of practice to provide educated professional opinions, discuss nutritional kinesiology, and prescribe stretches under ISSA guidelines when asked.
- At your request, I am prepared to communicate with your physician regarding your treatment plan. Written consent is required for physician communication and case-by-case insurance billing.

This is a **professional therapeutic environment**. Inappropriate behavior will not be tolerated and will result in immediate session termination with payment required.

I confirm that the information provided above is accurate and complete to the best of my knowledge.

Client Signature: _____

Date: _____