James Giacinto LMT. ***Orthopedic Massage Therapist***

Health Intake Form

An accurate health history ensures that it is safe for you to receive a massage treatment, and helps your therapist determine a proper treatment plan. When your health status changes in the future, please let me know. All information gathered on this form is confidential.

Name:_____ **Phone #:**_____
Address: _____
Email Address: _____
Occupation: _____**Date of Birth:**_____ **Age:**____
Have you received massage therapy before? Yes / No
How did you hear about me? _____
Referred By: _____
Did a health care practitioner refer you for massage therapy? Yes / No
If yes, please provide their name and address._____
_____
Doctor's name:_____**Address:**_____**Phone #:**_____
Do you see other healthcare practitioners?_____
Current Medications_____
Allergies/Hypersensitivities_____
Family history of_____
Major Accidents (include dates)_____
Other serious Medical Conditions_____
Injury/Surgery_____
Health Plan? Yes / No _____

Office use only

Date of initial heath history:
update 1_____
update 2_____
update 3_____
update 4_____

Notes:

Proactive Therapy NYC 928 Broadway Suite #600, New York, NY 10010
T. 516-768-1978 | ***E.*** james@proactivetherapynyc.com | ***W.*** proactivetherapynyc.com

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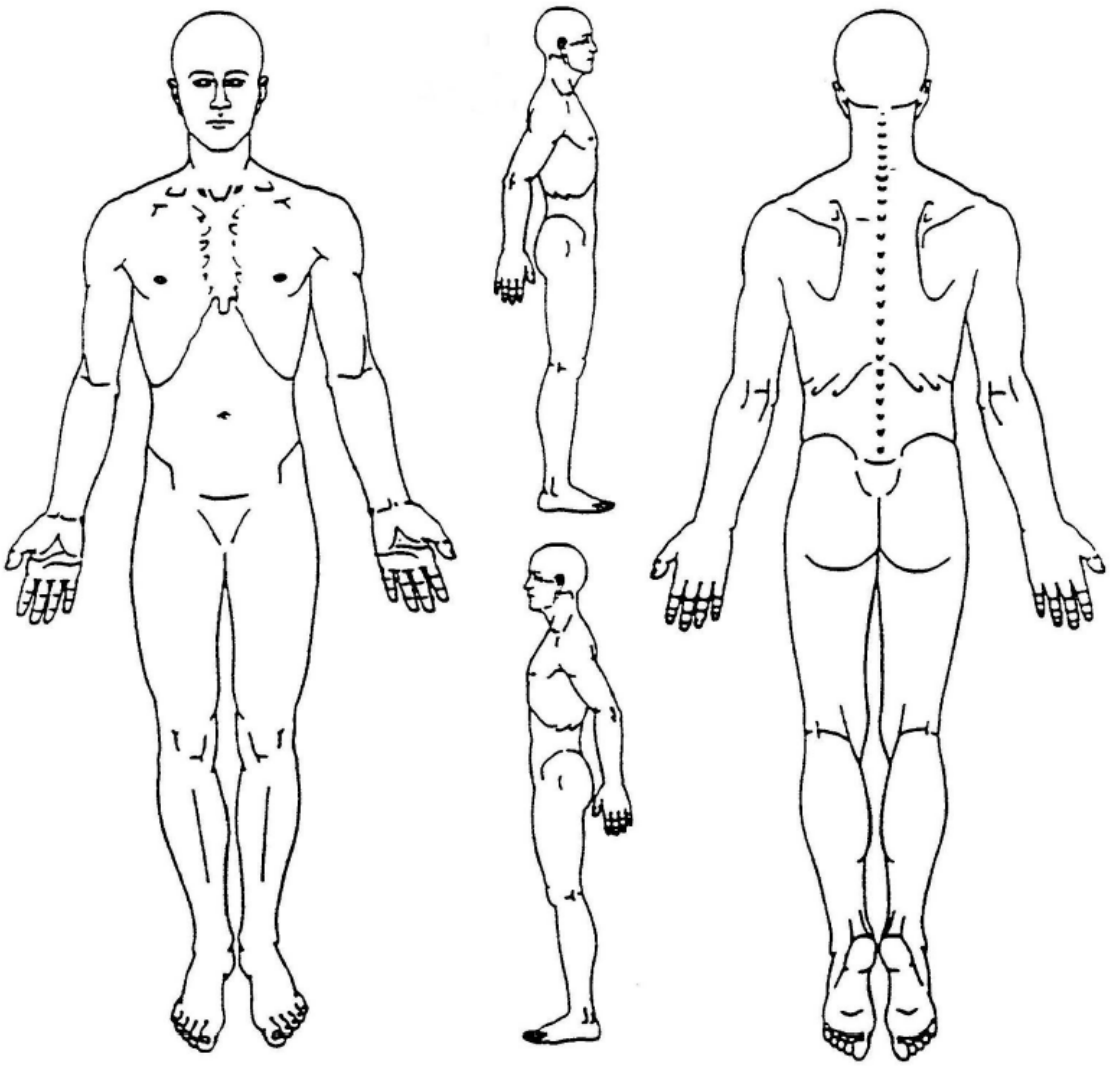
What is your main reason for your visit today?

_____

Are you presently in pain? Yes / No

On a scale of 1 – 10 what is your current level of pain? *(1 mild – 10 severe)* _____

Please indicate areas you would like me to focus on and your primary area(s) of pain or discomfort with an "X"



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Please check boxes and provide details for all that apply:

General Symptoms
❑ Fainting / Dizziness
❑ Difficulty Sleeping / Fatigue
❑ Stress
❑ Headaches / Migraines
❑ Nervousness
❑ Numbness / Tingling;
Where_____
❑ Paralysis

Skin
❑ Rashes
❑ Excessive Dryness
❑ Acne
❑ Psoriasis
❑ Eczema
❑ Skin Cancer
❑ Bruise Easily

Infections
❑ Hepatitis
❑ Tuberculosis
❑ HIV / AIDS
❑ Herpes
❑ Athlete's Foot
❑ Warts

Respiratory
❑ Chronic Cough
❑ Bronchitis
❑ Asthma
❑ Shortness of Breath
❑ Emphysema
❑ Family History of
_____
_____
_____

Cardiovascular
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Heart Attack / Disease
❑ Congestive Heart Failure
❑ Stroke / Aneurysm
❑ Pacemaker
❑ High Cholesterol
❑ Swelling of Ankles
❑ Cold Hands / Feet
❑ Poor Circulation
❑ Feet
❑ Varicose Veins / Phlebitis
❑ Family History of_____

Gastrointestinal
❑ Poor / Excessive Appetite
❑ Gas / Bloating
❑ Colitis
❑ Crohn's
❑ Constipation
❑ Diarrhea
❑ Nausea / Vomiting
❑ Ulcer
❑ Abdominal Cramps
❑ Gall Bladder Problems
❑ Liver Problems

ENT
❑ Vision Problems
❑ Sore Throat
❑ Ear Aches
❑ Hearing Difficulty
❑ Stuffed Nose / Sinus
❑ Allergies / Hypersensitivity to
_____
_____
❑ Swollen Glands

Joint / Muscle Discomfort
❑ Jaw
❑ Neck
❑ Shoulders
❑ Arms
❑ Hands
❑ Upper Back
❑ Mid Back
❑ Low Back
❑ Hips
❑ Legs
❑ Knees
❑ Feet
❑ Bursitis
❑ Arthritis
❑ Family History of Arthritis

Do You Have / Had?
❑ Diabetes Onset
❑ Cancer; Where
❑ Epilepsy
❑ Aneurysm / Stroke
❑ Neuromuscular Conditions
❑ Depression
❑ Multiple Sclerosis
❑ Thyroid Problems
❑ Fibromyalgia
❑ Osteoporosis
❑ Mental Illness
❑ Artificial Implants / Pins /
Plates; Where_____

Female
❑ Pregnant; Due Date_____

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Consent for Care

It is my choice to receive massage therapy. I am aware of the benefits and the risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions and injuries that I am aware of and will inform my practitioner of any changes in my health status and new injuries. If I experience pain or discomfort during my session, I will inform my therapist so that techniques can be adjusted to my comfort level.

By signing this release I hereby waive and release my therapist from any and all liability past, present, and future relating to sessions given by James Giacinto, LMT. I understand that should I cancel within 24 hours, I am subject to a cancellation fee.

Patient's Signature_____ **Date**_____

Cancellation Policy:

A scheduled appointment must be cancelled at least **24 business hours in advance** or you will be charged a cancellation fee of **$100.00** per session. (***Must cancel on Friday for a Monday appointment***). This fee is not billable to any insurance provider.

Patient's Signature_____ **Date**_____

Email Consent Policy:

New regulations require that anyone using email to communicate with healthcare providers understand and agree to certain conditions and limitations.

1. The transmission of patient information via email has a number of risks including, but not limited to: email is not secure; email can be intercepted, misaddressed, altered, forwarded, or used without authorization or detection; email may be circulated, forwarded and stored in paper and electronic files even after the sender or recipient has deleted his or her copy.

2. The Practice will use all reasonable means to protect the security of the email; however we cannot guarantee email confidentially. The Practice is not liable for improper disclosures unless they are caused by the Practice's intentional misconduct. I have read and understand the email disclaimer and give consent to Proactive Therapy NYC to correspond with me via email, if necessary.

Patient's Signature_____ **Date**_____

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