The Wellness Zone ~ Massage & Bodywork by Dustin Brubaker, LMP, CMT
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Client Health Intake and Consent for Care

Name: _____ DOB: ____/____/_____ Gender: M / F

Phone: (_____) _____ Preferred time to be contacted: Day / Evening / Any

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Marital Status: Single / Married / Other

Occupation: _____ Employer: _____ Phone: (_____) _____

Spouse Name: _____ DOB: ____/____/_____ Phone: (_____) _____

In case of emergency: Spouse / Other _____ Phone: (_____) _____

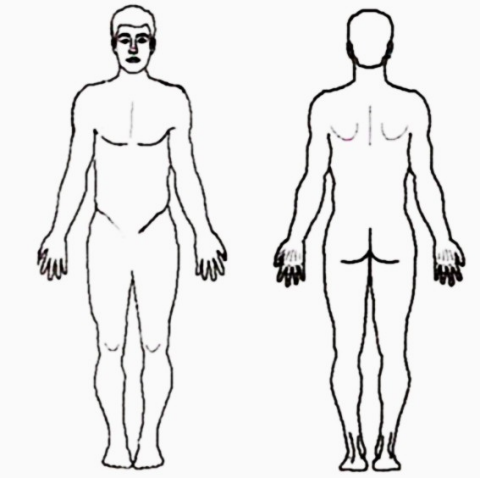
Primary Care Physician Name: _____ Phone: (_____) _____

Insurance Company: _____ Subscriber Name (if different): _____

Subscriber ID#: _____ Group #: _____ Plan Name: _____

Relationship to insured: Self / Spouse / Child Insured's Employer: _____

Mark an **X** on the body where you have pain or other symptoms:



Describe your current problem and how it began:

☐ Neck Pain ☐ Shoulder Pain ☐ Mid-back Pain ☐ Low-back Pain

☐ Other: _____

Are symptoms? ☐ Work Related ☐ Auto Related ☐ N/A

Claim #: _____

Adjuster/Rep: _____ Phone: (____) _____

If auto related, State in which accident occurred: _____

Date of first symptoms or injury: _____/_____/_____

Describe first symptoms or injury: _____

_____

How do you feel today? (Current level of pain or discomfort)

(NO PAIN) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (UNBEARABLE PAIN)

How often are your symptoms present?

(Intermittently) 0-20% ------- 21-40% ------- 41-60% ------- 61-80% ------- 81-100% (Constantly)

Have you had spinal X-Rays, MRI, CT Scan? Yes / No Date(s) taken: ____/____/_____ Areas: _____

Indicate each of the following conditions in your health history as: **No/Never = N / Past = P / Current = C**

N / P / C - Suffer from stress?	N / P / C - Bruise Easily?	N / P / C - Contagious Diseases?
N / P / C - Frequent headaches?	N / P / C - Pregnant?	N / P / C - Rashes?
N / P / C - Diabetes?	N / P / C - Swelling Joints?	N / P / C - Cancer/Tumor(s)?
N / P / C - High Blood Pressure?	N / P / C - Varicose Veins?	N / P / C - Pacemaker Device?
N / P / C - Arthritis?	N / P / C - Disturbed Sleep?	Conditions not listed:
N / P / C - Epilepsy/Seizures?	N / P / C - Allergies?	Surgeries:
N / P / C - Blood Clots?	N / P / C - Osteoporosis?	Medications:

Notes and Comments:

Initials: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork treatment before? YES / NO

If yes, how recently? _____ What kind of pressure do you prefer? Light / Medium / Deep

What are your massage and bodywork goals? _____

_____

Consent for Care

I certify, to the best of my knowledge, the information I have provided to be complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my massage/bodywork provider may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my massage/bodywork provider to contact my physician if necessary.

If I experience any pain or discomfort during treatment, I will immediately inform my massage/bodywork provider so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. I understand that massage/bodywork providers 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 given should be construed as such.

Contract for Care

I promise to participate fully as an active member of my health care team. I will make sound choices regarding my treatment plans based on the information provided by my massage/bodywork provider and other members of my health care team. I promise to inform my provider any time I feel my well-being is threatened or compromised. I expect my massage/bodywork provider to deliver safe and effective treatment.

Assignment of Benefits

My signature below authorizes and directs payment of medical benefits, for services billed, to my health care provider.

Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. I will inform my massage/bodywork provider immediately upon signing any exclusive Release of Medical Records with my attorney.

Client Signature: _____ **Date:** _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Dustin Brubaker, LMP to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Parent or Guardian Signature: _____ **Date:** _____

Practitioner Signature: _____ **Date:** _____