801 W Main St, Suite 1C
Bozeman, MT 59715
Ph. (406) 219-3631
Fax (406) 760-1809
www.ElevateHealthMT.com

GENERAL INTAKE

Name: _____ **Date of Service**:_____

Age: _____ **Date of Birth**: _____ **Gender**:_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone Numbers:

Please write number in the space provided	May we contact you at this number?	Can we leave messages for you at this number?
Home:	☐ Yes ☐ No	☐ Yes ☐ No
Work:	☐ Yes ☐ No	☐ Yes ☐ No
Cell:	☐ Yes ☐ No	☐ Yes ☐ No

Text Messages:
May we send you text messages including appointment reminders? ☐ Yes ☐ No

(If you opt in, we will send you text message appointment reminders when you have scheduled an appointment at Elevate Health. You can opt out at any time by contacting our reception at 406-219-3631. Agreement to receive a text message is not a condition of purchasing a good or service. Message and data rates may apply.)

Email:
Email Address:_____

May we contact you at this email, including sending you appointment reminders? ☐ Yes ☐ No

Would you like to be added to our email newsletter?: ☐ Yes ☐ No

Emergency Contact:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

How did you hear about Elevate Health?_____

Acknowledgment of Receipt of Notice of Privacy Practices
I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Elevate Health on this date.

_____ _____ _____ _____
Patient's Signature Date Parent/Guardian's Signature Date

_____ _____
Print Patient's Name Print Parent/Guardian's Name

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Acknowledgment of Responsibility for Payment and Payment Agreement

Welcome to Elevate Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read the following statements and sign below.

Payment: Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

Phone calls and emails: Phone calls and emails regarding an existing health issue that require more than 5 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Email replies that require more than 10 min of the doctor's time are $35. Phone calls are $65 per 15 min increment, billed in 15 min increments.

After hour calls: For non-life threatening health related emergencies you may reach your physician by calling the clinic and leaving a message marked "urgent" and stating you would like a call back. A $75.00 charge will be applied for pages to your physician. Additional charges maybe applied for additional services beyond responding to the page.

Late cancelations: We require 48-hour notice for canceling any appointments. There is a charge of 50% of the service cost incurred when less than 48-hours notice is given.

No shows: You will be charged the cost of any scheduled visit that you neglect to come to without a call to alert the clinic that you will not be able to make the visit. Special exceptions will be made for extenuating circumstances.

Supplements: Your health care provider may prescribe supplements, which may be purchased at the clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

Pharmacy prescriptions: Your health care provider may prescribe medications, which will be sent to the pharmacy of your choosing if possible. When you are due for a refill of these prescriptions please contact the pharmacy directly and they will send your doctor the refill request. A visit may be required for medication refill.
I have read and understand the above-stated policies of Elevate Health and will comply with them in all respects. I understand that I am financially responsible for the services provided to me by Elevate Health regardless of insurance coverage. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I also certify that I have read the Notice of Privacy Practices and understand that disclosure of my protected health information may be necessary to secure payment for health care services.

_____ _____

Patient Signature Date

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

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MASSAGE THERAPY INTAKE

Name:_____ DOB:_____

CONTEXT OF CARE REVIEW

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

1. Do you see any of our other providers at Elevate Health? ☐ Yes ☐ No
If so, who?_____

2. Are you currently receiving healthcare from any providers outside of Elevate Health? ☐ Yes ☐ No
If yes, please list provider's name, clinic, and specialty:_____

_____

3. Have you had a professional massage before? ☐ Yes ☐ No

4. Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No
If yes, please describe: _____

_____

5. Do you have any allergies to oils, lotions, ointments, fruits or nuts? ☐ Yes ☐ No
If yes, please detail: _____

_____

6. Are you wearing contact lenses? ☐ Yes ☐ No

7. Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
If yes, please describe: _____

_____

8. Do you perform any repetitive movement in your daily activities? ☐ Yes ☐ No
If yes, please describe: _____

_____

9. How do you feel the stress in your work, family, or other aspect of your life affects your health?

_____

_____

10. Do you feel stress causes any of the following: (check all that apply)
☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other_____

11. Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?
☐ Yes ☐ No If yes, please identify: _____

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MEDICAL HISTORY

1. Do you currently have or have you ever had any of the following? N=Now, P=Past (check all that apply)

	N	P		N	P		N	P
Phlebitis	☐	☐	Recent bone fracture	☐	☐	Heart condition	☐	☐
Tennis Elbow	☐	☐	Joint disorder	☐	☐	Decreased sensation	☐	☐
Blood clots	☐	☐	Deep Vein Thrombosis	☐	☐	Swollen Glands	☐	☐
Osteoporosis	☐	☐	Recent surgery	☐	☐	Circulatory disorder	☐	☐
Osteoarthritis	☐	☐	Rheumatoid Arthritis	☐	☐	Fibromyalgia	☐	☐
Tendonitis	☐	☐	Joint replacement	☐	☐	Atherosclerosis	☐	☐
Epilepsy	☐	☐	Sprains/Strains	☐	☐	Varicose veins	☐	☐
Current Fever	☐	☐	Headaches/Migraines	☐	☐	Contagious skin condition	☐	☐
Cancer	☐	☐	Neck or back problems	☐	☐	Allergies/Sensitivities	☐	☐
Diabetes	☐	☐	Recent accident or injury	☐	☐	Open sores or wounds	☐	☐
TMJ	☐	☐	Carpal Tunnel Syndrome	☐	☐	High or low blood pressure	☐	☐
Easy bruising	☐	☐						

2. Are you currently pregnant? ☐ Yes ☐ No If so, how many months?

3. Are you currently on any medications? ☐ Yes ☐ No (Please list all below)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

☐ No Known Allergies

Are you hypersensitive or allergic to:

Any drugs? ☐ No ☐ Yes_____

Any foods? ☐ No ☐ Yes_____

Any environmental or chemical allergies? ☐ No ☐ Yes_____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

_____

ELEVATE HEALTH

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Consent for Treatment - Massage

The undersigned ("Client") hereby freely consents to receipt of massage services from: Megan Goodman, LMT ("Therapist"). Client agrees as follows: Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.

2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not. Client understands that if he/she is under the influence of illegal drugs or alcohol, the client will be dismissed.

3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern all current and future therapy sessions performed by Therapist.

5. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform 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. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client's Signature	Date	Guardian/Representative's Signature	Date
Print Client's Name		Guardian's name and Relationship to Client	