Fostering Wellness

Client Initial Intake Form

Katherine Foster
Massage Therapist
2442 Larpenteur Ave West
St. Paul, MN 55113
(507) 219-5561

Client Last Name:_____

Client First Name:_____

Initial Intake Date:_____/_____/_____

Client Information

Address:_____

City:_____ State:_____ Zip:_____

Preferred Phone Number:_(_____)_____-_____ Birthdate:_____/_____/_____

Preferred Email Address:_____@_____

Emergency Contact:_____ Emergency Phone Number:_(_____)_____-_____

Gender:_____

Personal Health History

Please check any conditions/symptoms listed below that applies to you:

Musculoskeletal System
- ☐ Artificial Joint
- ☐ Baker's Cyst
- ☐ Bursitis
- ☐ Fibromyalgia or CFS
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Plantar Fasciitis
- ☐ Rheumatoid Arthritis
- ☐ Tendonitis
- ☐ Whiplash
- ☐ Other_____

Nervous System
- ☐ Alzheimer's
- ☐ Herpes Zoster/Shingles
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Numbness
- ☐ Other_____

Respiratory System
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sinusitis
- ☐ Other_____

Circulatory System
- ☐ Atherosclerosis
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other_____

Lymph/Immune System
- ☐ Allergic Reaction
- ☐ Chronic Fatigue
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Lymphoma
- ☐ Other_____

Digestive System
- ☐ Crohn's Disease
- ☐ IBS
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Other_____

Integumentary System (Skin)
- ☐ Athlete's Foot
- ☐ Boils
- ☐ Burns
- ☐ Cold Sore/Herpes
- ☐ Dermatitis
- ☐ Impetigo
- ☐ Open Sores/Wounds
- ☐ Psoriasis
- ☐ Rashes
- ☐ Warts
- ☐ Other_____

Miscellaneous Conditions
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness
- ☐ Pregnancy
- ☐ Other_____

Note: If ANY of the following items pertain to you, you MUST also have a physician's consent to receive massage therapy-heart attack, bypass surgery or angioplasty, stroke, heart murmur, chest pain, epilepsy, cancer or pregnancy. Please see "Physician's Consent Form" for more information.

How often do you typically consume alcoholic drinks (e.g. beer, wine)?

- ☐ Everyday
- ☐ Sometimes
- ☐ Not at all

How often do you typically consume caffeinated drinks (e.g. coffee, soda)?

- ☐ Everyday
- ☐ Sometimes
- ☐ Not at all

Do you use tobacco products (e.g. cigarettes, chewing tobacco, pipe, etc)?

- ☐ Yes, currently
- ☐ Yes, in the past (Year quit_____)
- ☐ No, never

On average, how much physical activity, exercise, or sports activities have you taken part in during the last month?

- ☐ None
- ☐ Less than 1 time/week
- ☐ 1 time/week
- ☐ 2-3 times/week
- ☐ 4 or more times/week

Please list any allergies:_____

Please list any surgeries you have had in the past, and their date:_____

_____

_____

Please list any traumas or injuries:_____

_____(Initials) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand massage therapist do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short-term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. **Consent for Treatment: I authorize the performance of massage therapy techniques and procedures and understand that I will receive them from a certified massage therapist.**

Client's Signature:_____ Date:_____/_____/_____

Massage Therapist's Signature:_____ Date:_____/_____/_____

HIPAA-Fostering Wellness, LLC Copy

Katherine Foster-Massage Therapist & Owner of Fostering Wellness, LLC

CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Fostering Wellness, LLC Pledge: Fostering Wellness, LLC is concerned with and committed to the protection of my patients' and clients' privacy and ensuring the confidentiality of personal health information entrusted to me.

Ways in which Fostering Wellness, LLC may use or disclose your health care information include, but are not limited to:

- Another health care provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Business associates that we contract with to perform a service for your benefit and bill for it.
- The use of that information to contact you by telephone (personal or work), Fax, Facebook, LinkedIn, mail and/or e-mail (personal or work) with appointment reminders, information about the massage therapy, treatment alternatives or other health-related information that may be of interest to you.
    - You may opt out of receiving communication from me. Please indicate which communication you would not like me contacting you through (check all that may apply):

O Telephone (Personal)	O Facebook	O E-mail (Personal)
O Telephone (Work)	O LinkedIn	O E-mail (Work)
O Fax	O Mail	

Along with this consent form, you will be given a copy of the privacy notice that describes the privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserved the right to change my privacy practices as described in that notice.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let us know in writing. We am not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on me.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if I have already released your health information before we receive your request to revoke your authorization.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION.

Initial Here

[ ] I acknowledge receipt of Fostering Wellness, LLC – Notice of Privacy Practices

By signing below, I give consent to the Fostering Wellness, LLC to disclose my personal health information.

_____
Printed Name

_____
Signature

_____
Date

_____
Authorized Representative

_____
Date