Massage Essentials ▪ Rachel M. Strenge-Malecha
406 Ivanhoe Ave ▪ Northfield, MN 55057 ▪ (507)664-9303

Client Intake Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell: _____

E-mail Address: _____

Occupation: _____ Employer: _____

Age: _____ Date of Birth: _____ Referred By: _____

Primary Health Care Provider: _____ Phone: _____

Do I have permission to consult with your heath care provider? Yes (please initial if yes) _____ No

Medications you are taking now, including aspirin, Ibuprofen, etc.:_____

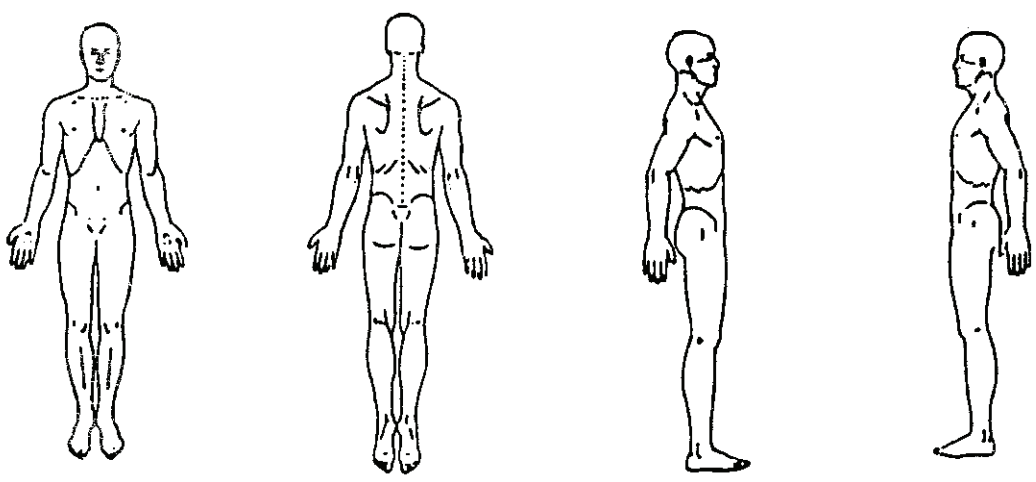
_____

Person to contact in Emergency: _____ Phone: _____

Massage History

1. Have you had professional massage before? Yes No
   If yes, frequency of massages: _____ Date of last massage: _____
   Where? _____
2. List Area(s) of Persistent Tension or Pain: _____
   _____
3. How long has this condition been bothering you? _____
4. What activities aggravate this condition? _____
   _____
5. List stress reduction activities you participate in: _____
6. What results do you want to achieve from your massage session? _____
   _____
7. Are there areas of your body that you prefer not to be massaged?_____
8. Prioritize the areas of your body that you would prefer to be massage:
   #1 _____ #2 _____ #3 _____

On the diagram provided, please mark an X or circle the area(s)
of tension, pain, or soreness that you are experiencing:



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Health History

Please answer the following questions by circling the appropriate answer and elaborating when necessary. This information is to help me provide the most beneficial and effective body work for you, and will be kept strictly confidential.

1. Do you wear contact lenses or dentures? Yes No
2. Are you sensitive to perfumes, lotions or oils? Yes No
3. Do you have any skin problems or allergies? Yes No
   Please explain: _____
   Treatment for? _____
4. Do you have heart problems? Yes No
   Please explain: _____
   Treatment for? _____
5. Do you have high blood pressure? Yes No
   Is it currently under control with medication? _____
6. Do you have varicose veins? Yes No
   Where? _____
   Treatment for? _____
7. Do you have arthritis, osteoporosis, brittle bones, or spinal problems? Yes No
   Please explain: _____
   Treatment for? _____
8. Do you have any lung or breathing problems? Yes No
   Please explain: _____
   Treatment for? _____
9. Do you have digestive tract problems? Yes No
   Please explain: _____
   Treatment for? _____
10. Do you experience hard or severe menstruation? Yes No
    Please explain: _____
    Treatment for? _____
11. Are you pregnant? Yes No
    If yes, how far along are you? _____
12. Have you experienced an illness or injury lately? Yes No
    Please explain: _____
    _____
    Treatment for? _____

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13. Are you currently seeing a psychotherapist or attending a regular support group meeting? Yes No
    If yes, please explain: _____
14. Do you have any other health problems I should be aware of? Yes No
    Please explain: _____
15. Do you exercise regularly or participate in sports? Yes No
    What type? _____ How often? _____
16. Have you experienced any acute injuries in the past 5 years? Yes No
    When? _____ Treatment? _____
    When? _____ Treatment? _____
    When? _____ Treatment? _____
17. Have you experienced any surgeries? Yes No
    When? _____ Treatment? _____
    When? _____ Treatment? _____
    When? _____ Treatment? _____

Discloser

I _____ understand it is my choice to receive massage therapy. I understand that the massage therapy given at Massage Essentials is being given for the well-being of my body and mind. This includes stress reduction, relief of muscular tension or spasm, or for increasing energy flow and circulation. I agree to communicate with Rachel Malecha anytime I feel my well-being is being compromised.

I understand that Rachel Malecha does not diagnose illness, disease, or any other physical or mental disorder. As such, she does not prescribe medical treatment, medications or perform spinal manipulations. I understand Rachel Malecha is a massage therapist only and will provide the service of therapeutic massage only. I understand massage therapy is not a substitute for medical examination, diagnosis or treatment and that I should see a physician for any physical ailment(s) that I might have.

Because Rachel Malecha must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep her updated on my physical health.

Signature: _____ Date: _____

Cancellation Policy

I understand that a one-session fee will be charged to me for missed appointments, or cancellations made without a 24 hour advanced notice.

Signature: _____ Date: _____

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Patient Health Information Concent Form

I want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before I begin any health care operations I must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of the policies and procedures concerning the privacy of your Patient Health information, I encourage you to read the HIPPA Notice that is available to review before signing this consent.

1. The patient understands and agrees to allow Massage Essentials to use the Patient Health information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Massage Essentials to submit requested PHI to Health Insurance Company (or companies) provided to me by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum need for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Massage Essentials is not obligated to agree to those restrictions.
3. A patients written consent need only be obtained one time for subsequent care to be given to the patient in this office.
4. The patient may provide written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy I have taken all precautions that are known by Massage Essentials to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with Massage Essentials about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, Massage Essentials has the right to refuse care to that patient.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

_____ _____

Signature of Patient Date

_____

Please print your name here

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Complimentary and Alternative Health Care Client Bill of Rights

As of July 1, 2001, the freedom of Access to Complimentary Care Law requires you receive and acknowledge by your signature below, a copy of the Complimentary and Alternative Health Care Client Bill of Rights prior to your treatment.

I _____

acknowledge by my signature that I have read and received the complimentary and Alternative Health Care Bill of Rights.

_____ _____

Clients Signature Date

Complimentary and Alternative Health Care Client Bill of Rights

Your practitioner holds a Bachelor of Science degree from the University of North Dakota and has received her massage training from Ohio College of Massotherapy and Northern Lights School of Massage. Your practitioner has had over 730 hours of training in the following: Basic Western Swedish style massage, Neuromuscular Therapy from Judith Walker-Delaney, Cross Fiber Friction Therapy, Trigger Point Therapy (based on the teachings of Janet Travelle, MD), Connective Tissue Massage and Reiki from John Latz, Heated Stone Massage, Ear Candling, Anatomy, Physiology, and Ethics and Professionalism. Your practitioner is a member of the American Massage Therapy Association and is Nationally Certified in Therapeutic Massage and Body Work.

"The state of Minnesota has not adopted any educational training standards for unlicensed complimentary and alternative health care practitioners. This statement of credentials is for information purposes only. Under Minnesota law, an unlicensed complimentary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatment. If a client desires a diagnosis from a licensed physician, chiropractor, nurse, osteopath, physical/ occupational therapist, dietitian, nutritionist, acupuncturist, athletic trainer, or any other health care provider, the client may seek such services at any time."

- You have the right to express concerns or file complaints with the Minnesota Department of Health, Health Occupations Program, P.O. Box 64975, St. Paul, Minnesota, 55164, (651) 282-6366.
- Fees at Massage Essentials are $85.00 for one and one-half hour, $60.00 for one hour, $35.00 for one-half hour massage, $45.00 for ear candling, $45.00 for 15 minute session of Connective Tissue Massage, Neuromuscular Therapy and Trigger Point Therapy, which includes a 6.0875% Minnesota sales tax. Clients that have been referred by a licensed practitioner and provide a written documentation from their licensed practitioner are exempt from Minnesota sales tax. Payment is expected at time of service by cash or check only. Insurance billing is accepted with completion of insurance form and written referral from a licensed practitioner. A $5.00 fee will be added to a client's initial visit. A $10.00 fee will be added for heated stone massage. A $20.00 fee will be added to all services provided outside the office.
- You have the right to reasonable notice of changes in services and charges. Such notice will be given verbally and will be posted in the treatment room 30 days in advance.
- Massage is the systemic and scientific manipulation of the soft tissue structures of the body to prevent and alleviate pain, discomfort, muscle spasms and stress: and to promote health and wellness.
- You have the right to complete and current information concerning any massage specific assessment your practitioner has made and any recommended services to be provided, including the expected duration of services.
- You can expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
- Your records and all transactions with "Massage Essentials" are confidential, unless the release of these records is authorized in writing by you or otherwise provided by law.
- You have the right to access and read your records in accordance with state law section 144.355.
- If other massage and bodywork services are available in your community, your therapist would be happy to assist you in finding information about them and other practitioners.
- You have the right to choose freely among massage and body work practitioners, and to change practitioners after services have begun, with in limits of health insurance or other health programs.
- You have the right to coordinate transfer of your records when there will be a change in the provider of services. If you choose to see another massage therapist or health care provider, your records will be transferred at your request.
- You have the right to refuse services at any time during a massage therapy session. You may assert any of the previous rights without retaliation.