Intake / Health History Form

Please fill out the form and return to the office using any of these 3 options:

- Print and bring this form with you to your appointment OR
- Fax the form to 888-490-9737 – free e-fax options are available OR
- Email to deb@debkimmet.com – this option is not secure and not HIPAA compliant

Name _____

Referred by _____ May we send them a thank you? ◯ Yes ◯ No

Date of Birth (mm/dd/yyyy) _____ ◯ Male ◯ Female ◯ Other ◯ Not specified

Email _____ Preferred Phone _____ ☐ Cell

Address _____ City _____ State _____ Zip _____

Emergency contact _____ Phone _____ Relationship _____

Primary Physician/Health Care Provider _____ Phone _____

Occupation _____

Please indicate if you are currently experiencing any of the following:

☐ Blood Clots ☐ Infections ☐ Congestive Heart Failure ☐ Contagious Diseases ☐ Pitted Edema

Massage may be contraindicated when the above conditions are present. Please call our office (406-544-4704).

PURPOSE OF VISIT: What do you wish to achieve from this work? / What are your goals?

Please indicate conditions that you currently have OR have had in the past.

Current	Past		Current	Past		Current	Past	
☐	☐	Allergies	☐	☐	Varicose veins	☐	☐	Dizziness
☐	☐	Asthma / Shortness of breath	☐	☐	Swelling	☐	☐	Ringing in ears
			☐	☐	Lymphedema	☐	☐	Frequent Indigestion
☐	☐	Respiratory illnesses	☐	☐	Osteoporosis	☐	☐	Other digestive conditions
☐	☐	Arthritis	☐	☐	High / Low blood			(Crohn's / IBS)
☐	☐	Diabetes			Pressure	☐	☐	Hepatitis
☐	☐	Skin conditions	☐	☐	Cancer	☐	☐	HIV / AIDS
☐	☐	Easily bruised	☐	☐	Headaches / Migraines	☐	☐	Other infectious
☐	☐	Stroke / Heart attack	☐	☐	Fainting Spells / Epilepsy /			conditions
☐	☐	Heart disease			Seizures	☐	☐	Depression / Anxiety
☐	☐	Kidney Disease / Infection	☐	☐	Endocrine / Thyroid conditions	☐	☐	Sleep Disturbance
☐	☐	Neurological (Parkinson's, MS, chronic pain)	☐	☐	Numbness / Tingling / Stabbing Pain			

Please provide details, including treatment received for the items checked above.

Please indicate Injuries / Trauma that you are currently recovering from OR have had in the past.

Current	Past		Current	Past		Current	Past	
☐	☐	Concussion / Head Injuries	☐	☐	Fractures	☐	☐	Dislocations
☐	☐	Hospitalizations	☐	☐	Surgeries	☐	☐	Other Injuries / Trauma

Please provide details, including the year treatment was received for the items checked above.

Women: Check the box if you:

☐ Have had a C-Section ☐ Are currently pregnant / Trying to get pregnant?

General: Check the box if you wear:

☐ Contacts ☐ Dentures ☐ Mouth Guard or other appliance ☐ Orthotics / Heel Lifts / Other Foot Support

Are you presently under the care of a medical professional (such as MD/DO, PT, Naturopathic Physician, Chiropractor, Acupuncturist, Mental Health Professional)? If so, please specify.

Medications: Please list your current medications and purpose of the medication.

What is your major complaint?

_____

Severity on a scale of 1 to 10 (10 being the worst), rate your pain level _____

Other areas of pain or concern (minor complaints)?

_____

When did you first notice the major complaint?

_____

What brought it on? (include date of accident if applicable)

_____

What activities aggravate the condition?

_____

What activities relieve the condition?

_____

Is the condition getting progressively worse? ◯ Yes ◯ No ◯ It is constant ◯ It comes and goes

Is this condition interfering with your (check all that apply): ☐ Work ☐ Sleep ☐ Daily routine

At night it is ◯ Better ◯ Worse ◯ The same

What do you believe is going on with you?

_____

What have you done *this time* to get relief?

_____

Has there been a medical diagnosis? ◯ Yes ◯ No If yes, what was the diagnosis?

_____

By whom?

_____

Were there X-rays? ◯ Yes ◯ No Blood work? ◯ Yes ◯ No

Other diagnostic tests (Specify)?

_____

Have you ever had a similar problem before? ◯ Yes ◯ No If yes, when?

_____

What caused those episodes?

_____

What relieved them?

_____

What was the previous diagnosis?

_____

Is there anything else about your health that hasn't been asked that we should know in order to provide an effective session?

_____

DURING THE TREATMENT:

- Breathe! Exhaling releases tension. Holding your breath retains tension.
- Breathe! When the practitioner is applying pressure or stretching a muscle, also release your breath and your muscles will relax more easily.

CONSENT TO TREAT / WAIVER:

Marking each box below means that you have read and agree to all of the following statements:

☐ I understand the purpose of the session is intended to enhance relaxation, reduce stress, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.

☐ I understand that if anything feels painful or uncomfortable I will tell my practitioner immediately so the technique may be adjusted to my level of comfort and safety.

☐ I understand that massage therapy, bodywork, movement education, and exercise 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. It is recommended that I inform my other caregivers that I am also receiving massage therapy, bodywork, movement education, and exercise as part of my self-care program.

☐ I understand that the practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe medication, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Information exchanged during a session is educational in nature and is to be used or followed at my own discretion and at my own risk.

☐ Because massage therapy, bodywork, movement education, and exercise should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and medications and answered all questions completely. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

☐ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

☐ Understanding all of this, it is my choice to receive massage therapy, bodywork, movement education, and exercise. I give consent to receive care / treatment.

Client Signature* _____ Date _____

Consent to Treatment of Minor:
By my signature below, I hereby authorize Deborah Kimmet to administer massage therapy, bodywork, movement education, and exercise to my child or dependent as deemed necessary.

Signature of Parent or Guardian* _____ Date _____

*A typed full name is also a valid signature.

Policies and Disclosures

If you booked your appointment online:

There's nothing to do here - This page is informational only as you already agreed to these provisions during the intake process.

If you made your appointment directly with Deborah (via phone, text, or email):

Please fill out this form and return with the rest of your intake materials.

Cancellation & Late Arrival Policy

At least 24-hour notice of cancellation is expected. An appointment is considered cancelled without notice if a client is 15 or more minutes late. If a client arrives with a cold, infection, or other illness, it is likely that Deborah Kimmet will not provide the session. In all instances, the client will be assessed and pay the cost of the scheduled appointment time.

If a client is late for a session, the late time will be deducted from the session time and the client will still be responsible for paying for the originally scheduled time.

More about the Cancellation & Late Arrival Policy can be found at https://www.debkimmet.com/uploads/1/1/3/0/113029991/2_cancellation_policy_form.pdf

Provider Disclosure

Deborah Kimmet is a massage therapist and corrective exercise specialist and is not a physician or physical therapist. The Provider Disclosure document outlines Deborah's background and legal status as well as the nature and legal status of the services provided, and other information. A client can request a copy of this document or can access it online at https://www.debkimmet.com/uploads/1/1/3/0/113029991/2_legal_disclosure_provider_background.pdf

Privacy Policy

The Privacy Policy outlines how medical records are administered. A client can request a copy of this document or can access it online at https://www.debkimmet.com/uploads/1/1/3/0/113029991/2_legal_disclosure_privacy_policy.pdf

By signing below, I acknowledge that

- I have read and understand the policy and disclosure statements above, and I understand that can get more information about them by following the links, and
- I understand and agree to the terms of the cancellation & late arrival policy for this and future appointments.

Client Signature* _____ Date _____

Printed Name: _____

*A typed full name is also a valid signature.