Stony Brook Southampton Hospital
240 Meeting House Lane, Southampton, NY 11968 Tel: 631-726-8800, Fax: 631-726-8748

MASSAGE THERAPY PATIENT INTAKE

Name: _____ **DOB:** _____ **Phone**: _____ **E-mail:**_____

Emergency contact: Name: _____ Phone: _____ Relationship: _____

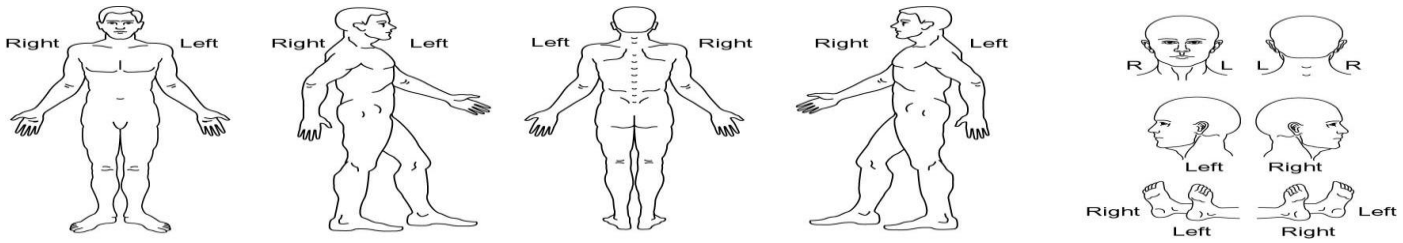
Allergies: List any medication (s) or food that you are allergic to: _____

Are you latex sensitive? ◯ **Yes** ◯ **No**

What brings you here today?_____

If you have pain, please indicate on the 0-10 what level your pain is: _____

Please indicate on the diagram(s) below where your symptoms are:



Have you ever been diagnosed as having any of the following conditions?

◯ Yes ◯ No Cancer If yes, what kind? _____
◯ Yes ◯ No High blood pressure
◯ Yes ◯ No Heart Disease / Problems: list: _____
◯ Yes ◯ No Circulation Problems / Varicose Veins
◯ Yes ◯ No Stroke: date: _____
◯ Yes ◯ No Asthma
◯ Yes ◯ No Chemical Dependency
◯ Yes ◯ No Thyroid Problems
◯ Yes ◯ No Diabetes
◯ Yes ◯ No Kidney disease

◯ Yes ◯ No Epilepsy
◯ Yes ◯ No Osteoarthritis: where: _____
◯ Yes ◯ No Rheumatoid Arthritis
◯ Yes ◯ No Other Arthritic Conditions: _____
◯ Yes ◯ No Multiple Sclerosis
◯ Yes ◯ No Emphysema / Chronic Bronchitis
◯ Yes ◯ No Lyme Disease
◯ Yes ◯ No Liver Disease
◯ Yes ◯ No Tuberculosis
◯ Yes ◯ No Anemia

Have you recently noticed any of the following?

◯ Yes ◯ No Weight loss / gain
◯ Yes ◯ No Nausea
◯ Yes ◯ No Fatigue

◯ Yes ◯ No Weakness : where? _____
◯ Yes ◯ No Fever / Chills / Sweats
◯ Yes ◯ No Numbness / Tingling: where? _____

Please list any surgeries or significant injuries that you've been treated for?

	Reason	Date
1.	_____	_____
2.	_____	_____

Please list any prescription medications you are currently taking:

_____

_____

Are you currently pregnant or think you might be pregnant? ◯ YES ◯ NO
Do you have a pacemaker, implanted medication port or defibrillator? ◯ YES ◯ NO
Do you use an assistive device? ◯ YES ◯ NO _____ Cane/ Walker /Crutches/Other
Do you have a history of Falls? ◯ YES ◯ NO

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Southampton Hospital

Consent to Treat

If I experience any pain or discomfort during the 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 Therapy 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. 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.

Signature _____ Date _____

Welcome to Stony Brook Southampton Hospital Massage Therapy Department

Stony Brook Southampton Hospital's Massage Therapy Department would like to thank you for selecting us as your provider of Massage Services. We will do everything possible to assure that your treatment is of the highest quality. To ensure that we can continue to deliver this quality of service, we have established the following guidelines.

Please contact us if you anticipate arriving more than 15 minutes late for your appointment to determine if we will still be able to meet your needs. If you are unable to keep an appointment and do not call to cancel 24 hours in advance, we will not be able to use that time to schedule another patient in your place. **In that case, you will be charged the full fee for your massage session. It will be your responsibility to pay. This fee must be paid before your next scheduled appointment.** The intention of this policy is to enable us to utilize all our treatment slots to meet the increasing need for our patients. We appreciate your cooperation and will do our best to accommodate your needs.

Signature_____ Date _____

Release of Medical Records

I authorize the release of any medical information necessary to my physicians, and my insurer to process claims or authorize visits. This information may include history and date of current illness, medical and surgical history, diagnostic results as well as information regarding progress during my rehabilitation.

Signature_____ Date_____

Privacy Notice Acknowledgment of Receipt

I, _____, acknowledge that I have been provided with a copy of
(Print Name
Southampton Hospital's privacy notice.

Signature_____ Date_____

Advanced Directives

Do you have an Advanced Directive (Living Will, DNR, Health Care Proxy)? Yes_____ No _____
If **YES**, please bring in a copy to keep on file in your chart.