dreamclinic
keep your health

CONFIDENTIAL CLIENT INTAKE FORM

PERSONAL INFORMATION

Please print clearly and complete all fields.

Name _____ Date of Birth _____

Address_____ City_____ State_____ Zip_____

Primary Phone _____ Email address_____

How did you hear about us? (Referrer's name if applicable) _____

Emergency Contact _____ Emergency Contact Phone _____

Employer_____ Occupation_____

MASSAGE/ACUPUNCTURE HISTORY / TREATMENT INFORMATION

Have you ever received a professional table massage? ☐**Yes** ☐**No** Date of last massage _____

Have you ever received acupuncture? ☐**Yes** ☐**No** Date of last acupuncture session _____

List any exercise and stress reduction activities and frequency: _____

_____

Are there specific areas of your body you want the massage to focus on today? _____

_____

What results do you want from your massage sessions? _____

_____

PREVIOUS HISTORY

Allergies: _____

Surgeries: _____

_____

Injuries/Accidents: _____

_____

Major Illnesses or other hospitalizations: _____

_____

Are you currently seeing a medical practitioner? ☐ Yes ☐ No If yes, please give name and location:

_____

If necessary, do we have permission to consult with your medical practitioner? ☐ **Yes** ☐ **No**

Are you currently seeing a psychotherapist or attending support group meetings? ☐ **Yes** ☐ **No**

Please explain if yes: _____

_____

List current medications, including aspirin, ibuprofen, etc. _____

_____

Please identify any of the following, which you now have or have had in the past:

Now	Past		Now	Past		Now	Past	
Skin Conditions			**Nervous System Conditions**			**Digestive Conditions**		
❑	❑	Rash	❑	❑	Numbness	❑	❑	Constipation
❑	❑	Allergy	❑	❑	Tingling	❑	❑	Diarrhea
❑	❑	Fungal Infection	❑	❑	Nerve Damage	❑	❑	Ulcer
❑	❑	Other	❑	❑	Shingles	❑	❑	Other
			❑	❑	Other			
Muscle Conditions								
❑	❑	Strain	**Respiratory Conditions**			**Other Conditions**		
❑	❑	Tendonitis	❑	❑	Sinus			
❑	❑	Spasm	❑	❑	Lung / Bronchial	❑	❑	_____
❑	❑	Cramp	❑	❑	Other			
❑	❑	Other				❑	❑	_____
			Circulatory Conditions					
Joint Conditions			❑	❑	Heart	❑	❑	_____
❑	❑	Sprains	❑	❑	Blood Pressure			
❑	❑	Arthritis	❑	❑	Arteries	❑	❑	_____
❑	❑	Degenerating Joints	❑	❑	Veins			
❑	❑	Other	❑	❑	Other			

I have listed all my known medical conditions such as surgeries, injuries, diseases, physical limitations and medications and will inform the massage therapist of any change in my physical health between massage sessions. I understand that a massage practitioner must be aware of any existing physical conditions that I have in order to provide appropriate massage.

I also understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have.

I understand that massage does not involve any form of touch of genitalia or nipples and I understand that these areas will be draped at all times during the massage. Should the massage practitioner not be clear and acting differently from these expectations, I agree to speak to him or her any time I feel my wellbeing is being compromised.

CLIENT FEES **Client Initial Here_____**

Dreamclinic is committed to providing all of our clients with exceptional care. When a client cancels without giving enough notice, they prevent another client from being seen.

Dreamclinic requires at least **24 hours' notice** if you need to cancel or reschedule your appointment for any reason. For no-shows or cancellations with less than 24 hours' notice, Dreamclinic Inc. will charge a cancellation or rescheduling fee.

As a courtesy to your massage therapist, if you arrive at least **15 minutes late** to an insurance appointment, Dreamclinic Inc. will charge you a late fee. Cancellation and late fees cannot be billed to insurance. If you arrive late to a non-insurance appointment, your session will be billed the full rate while we may have to shorten the duration of the session.

INSURANCE POLICIES **Client Initial Here_____**

Once you have used your insurance in a calendar year, you are considered an insurance client until such time as you have used all your allowed services for that calendar year, or wish to pay cash for non-covered services.

We cannot bill your secondary insurance at this time. We will provide you with information to self-bill if requested.

My signature below indicates that I have read and understand all the statements above.

Client Signature _____ **Date_____**

dreamclinic™

916 NE 65th Street. Seattle WA 98115 206-267-0863 www.dreamclinic.com

Notice to Clients – Dreamclinic Inc. Massage and Acupuncture Privacy Practices

Dreamclinic is dedicated to excellence and integrity for the massage and bodywork profession. Our licensed massage therapists (LMTs), licensed acupuncturists (LAcs) and staff are expected to follow appropriate professional standards for maintaining client confidentiality. Our confidentiality and privacy practices are as follow:

Client Records

Client records are maintained in a confidential manner, kept in a file folder which is to be secured in a locked file when not in use by the LMT, LAc or being reviewed by Dreamclinic Inc. staff for administrative purposes.

Client Rights

Clients may request, in writing to see or obtain a copy of their records. The client may request that corrections be made if they identify errors or mistakes. Access to records will be made during regular business hours within 30 days of receipt of written request and a fee may be charged for copying and sending requested records. Requested records are sent standard US Mail unless the client requests they are sent via express mail (at client's expense). Records are not available by email.

Use of Records

Dreamclinic, Inc. LMTs and LAcs maintain client records. No records are released without the written authorization of the client unless compelled by law. LMTs and LAcs use client records when providing massage and acupuncture services to individual clients. Client records may be discussed and reviewed by Dreamclinic, Inc. staff for insurance purposes or treatment planning.

Disclosure of Records

All Dreamclinic Inc. LMTs and LAcs are provided access to client records since the client may be seeing more than one therapist. At no time are client records and information released to anyone outside of Dreamclinic Inc. without written request and release from the client unless compelled by law (such as subpoenas), or for insurance billing.

Privacy Officer Contact Information

Larisa Goldin, LMT and CEO
Dreamclinic Inc.
916 NE 65th St.
Seattle, WA 98115
206.267.0863
service@dreamclinic.com

I (please print) _____ have received, read and understand this privacy policy as it relates to receiving massage from a Dreamclinic LMT or an acupuncture treatment from a Dreamclinic LAc.

Client Signature_____ Date_____

dreamclinic
keep your health

Informed Consent and Permissions for Specific Massage

Below are four specific and uncommon physical areas that can be attended to by a qualified practitioner. Please select your level of comfort so that your practitioner is aware. If you are unsure, your practitioner may be able to provide you with greater detail around these areas as they fit into your individual needs.

Intention: Massage is intended to decrease muscle tension, tissue restrictions, and pain in the area being massaged as well as in related areas.

Procedure: Your massage therapist will assess your muscles and tissue status in order to determine the best course of massage treatment for your health goals. Your therapist will then share this treatment plan with you before proceeding.

In order to customize your session to your needs and preferences, please initial below for specific sensitive areas you may require work on:

1 - consent to massage uncovered 2 - consent to massage covered 3 - no massage in the area

	(1)	**(2)**	**(3)**
A. Inner thigh (adductor muscles):	_____	_____	_____
B. Pectoral muscles, Ribcage, and Armpit:	_____	_____	_____
C. Abdomen:	_____	_____	_____
D. Intra-Oral Massage*****:	_____		_____

***Disclaimer: Intra-Oral Massage requires state endorsement and certifications. Please ask our front desk to schedule you with endorsed practitioners for this type of massage.*

As a client, I understand that I have the right to stop treatment at any time during my session if I feel uncomfortable for any reason.

Printed Name:_____

Signature: _____

Date: _____