Jennifer Wiegand LMT, QTTT, CMLDT

19063 12th Ave NE ▪ Poulsbo, WA 98370 ▪ 360-434-1454 office

jenwiegandTT@gmail.com www.jenwiegandTT.com

CONFIDENTIAL CLIENT INTAKE FORM

Name____ Date_______________________

Adress____ City______________________State_______

Zip ____________ Home Phone________________________ Work______________________________

Cell Phone________________________ DOB__________ Occupation______________________________

Emergency Contact & Phone____

Referred by____

1. What is your primary complaint? ____
2. Secondary Complaint?____
3. What date did your symptoms begin?________________________
4. How did your symptoms begin?____
5. Did you receive treatment for this condition? ☐ Yes ☐ No
6. If yes please indicate type of treatment, dates, and effectiveness ____________________________
   ____
   ____
7. What aggravates your symptoms?____
8. What decreases your symptoms? ____
9. What are your goals in seeking treatment?____
10. What kinds of activities are limited or cannot be performed now, that you used to do? Please be specific____
    ____
11. How much improvement in your symptoms do you believe is possible?
    ____

MASSAGE HISTORY/TREATMENT INFORMATION

What type of bodywork have you received in the past?____

Date of last session_________________

List any stress reduction activities, including frequency____

Would you like me to teach you some stress reduction techniques during your session? ☐ Yes ☐ No

Who is your primary care physican?____

What was the date of your last physical and what were the results? ____________________________________

____

Are you currently under a doctors care? ☐ Yes ☐ No

If Yes, for what? ____

List current medications, herbs, vitamins____

____

____

PREVIOUS HISTORY (please include year and treatment received)

Injuries/Accidents ____

____

____

Major Illnesses, Surgeries or Hospitalizations ____

____

____

Traumatic Life Events ____

____

Please mark any of the following that you have *NOW* or in the *PAST* with a **N** or **P** and circle the applicable condition if there are two on the same line.

NERVOUS SYSTEM
____ Shingles
____ Sciatica
____ Numbness/tingling
____ Pinched nerve
____ Bell's palsy
____ Trigeminal neuralgia
____ other

CIRCULATORY
____ Heart condition
____ Phlebitis
____ Blood Clots
____ High/Low Blood Pressure
____ Lymphedema
____ Thrombosis/Embolism
____ other

SKIN
____ Allergies
____ Rashes
____ Athletes foot
____ Herpes/cold sores
____ other

MUSCULOSKELETAL
____ Bone or Joint Disease
____ Tendonitis/bursitis
____ Arthritis/gout
____ Sprains/strains
____ Low back/hip/leg pain
____ Neck /shoulder/arm pain
____ Spasms/cramps
____ Jaw pain/TMJ
____ Lupus
____ Osteoporosis
____ other

DIGESTIVE
____ Constipation/diarrhea
____ Gas/Bloating
____ Diverticulitis
____ IBS
____ Ulcers
____ other

RESPIRATORY
____ Breathing difficulty/Asthma
____ Emphysema
____ Allergies
____ Sinus problems
____ other

REPRODUCTIVE
____ Pregnant: stage________
____ Ovarian/menstrual problems
____ PMS
____ Prostrate
____ other

OTHER
____ Cancer/Tumors
____ Kidney/Bladder ailment
____ Diabetes
____ Drug/Alcohol/caffeine/tobacco use (how often?)_____________
____ Chronic Fatigue
____ Chronic Pain
____ Sleep disorders
____ Migraines/headaches
____ Anxiety/stress syndrome
____ Inflammation/swelling (where, when?) ____________________
____ Communicable Diseases(specify)
____ Contact lenses
____ Infection
____ Fever

Dear Client,

I look forward to working with you. We will work as a team to restore function and decrease any pain you may currently be experiencing. The following information is my office/financial policy, and some session guidelines. Please read carefully and sign. A one hour session is $110, an hour and a half $160, payable at the time of your appointment, cash or check. Credit cards may be used 24 hours prior to your appointment by using the PayPal function on my website www.jenwiegandtt.com

It is not customary nor expected to tip a medical health professional.

Insurance billing is the patient's responsibility. I will provide you with an invoice to take care of your insurance reimbursement. Check with your insurance customer care line for coverage and eligibility before your scheduled appointment.

For myofascial release therapy sessions:
Women - please wear or bring a two piece bathing suit, sports bra, and loose gym shorts, or bra and underpants for your session. **Men** – loose gym shorts with an elastic band is sufficient. This allows me to see your myofascial restrictions during the postural analysis and during your treatment session.

For proper myofascial release to occur, do not wear any lotion or oil on your skin the day of your session as it is important to have a good purchase on the skin and not slide. If at any time during the session, anything feels uncomfortable, please let me know so that I can adjust the pressure and technique to your particular needs.

Please sign and date the following - I have read the above information and discussed it with my practitioner, Jennifer Wiegand. I understand that this work does not constitute medical treatment, but rather is a form of health promotion, utilizing the techniques and principles of traditional Chinese Medicine, Myofascial Release, Trigger Point Therapy, Reiki, Therapeutic Touch, Swedish Massage, Cranial Sacral techniques, and Manual Lymphatic Drainage. I take responsibility for alerting my practitioner, Jennifer Wiegand, to any physical conditions which affect me at this time, and in future sessions. I further understand that a massage therapist, neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder, nor performs any thrusting joint or spine on manipulations or adjustments. I am responsible for consulting a qualified primary care provider for any ailment I may have.

I agree to give at least 24 hours' notice if I must cancel my appointment. I also agreed to arrive on time for my scheduled appointment. Payment is expected for my appointment if canceled or missed without a minimum of 24 hours' notice. Insurance will not pay for missed sessions. When you commit to a certain time and day for your session you eliminated that period of time as an option for some other client. Therefore, as part of the therapeutic contract, you are responsible for that time. No further appointments will be scheduled until payment is made. Your signature below signifies that you agree to abide by this part of the therapeutic contract.

Signed ____ Date _______________