Client Intake Form

All Information Strictly Confidential

Name _____ **Date of Birth** _____

Address _____ **Emergency Contact** _____

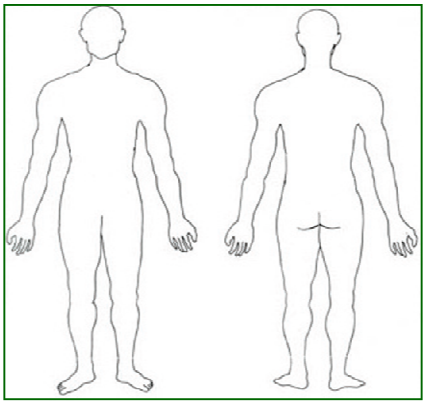
City _____ **Phone** _____

Zip _____ **Referred By** _____

Home Phone _____ **Area of Pain**

Cell phone _____

Please note on the bodies to the right where you are feeling pain or discomfort



Email (for appointment reminders) _____
Inform me of appointment openings? Yes No (please circle one)

Join Quarterly Newsletter? Yes No (please circle one, I do not SPAM)

Medical Conditions and ALL Current Medications
If you currently have or have had any of the following medical conditions or incidents, please indicate type of condition if necessary and year of occurrence.
Some medical conditions and medications may be contraindicated by massage._____
_____

Pain Scale (1 being the best and 10 being the worst)
1 2 3 4 5 6 7 8 9 10

Please describe the nature of your condition at this time
_____
_____

When did your condition first begin? _____
Cause of condition (circle all that apply & explain) reoccurrence repetitive trauma unknown/gradual other explain: _____
_____
Have you had anything like this before? _____
Is the pain (circle) constant on & off
Lately, has the pain been (circle) getting better getting worse staying about the same
What makes it feel better? _____
or worse _____

Have you ever had a professional therapeutic massage? **Yes No**

Are you allergic or sensitive to nut oils? **Yes No**

Are you sensitive to heat or cold?
Heat Cold Both No

Intestinal Bloating **Yes No**

If you have seen another professional for this problem, or done any self-care, describe the type of treatment and results _____
_____
_____

Please list any activities you are unable to perform/have not performed due to pain. _____
_____

I understand that the services of the therapist are not a substitute for professional medical care. If needed, I grant permission for any reason, or not treat any area of condition through our therapies that you feel would have adverse effects on me. I understand that if being referred by a physician for treatment, the therapist will defer to that physician's orders as the primary goal of treatment. **Cancellation Policy:** We require 24 hours advanced notice of cancellation. No-show, missed appointments will be charged for a the full session, and a late cancellation fee of $25 may be charged in the event of a cancellation less that 24 hours if the appointment cannot be filled with another client. If arriving late for an appointment, the session will still end on time, with full payment due. I have read and understand the cancellation policy and guidelines outlined above regarding treatment.

_____
Client Signature Date

Neuromuscular Therapy
Mara Nicandro NMT
"Elite Care Leads To Effective Muscle Recovery"

Mara Nicandro NMT, MMT, NKT™ , Nctmb **(312) 451-5771 2225 West North Ave. Chicago, IL 60647**

Client Consent for the Purposes of Treatment,
Payment, and Health Care Operations

I _____ give consent to ___Mara Nicandro NMT_____ for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice.

I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods (fill in only those methods by which you desire to be contacted):
Home Telephone: Work Telephone:
Cell Phone: e-mail:

Marketing: Occasionally we send out newsletters, announcements and special occasion cards. If you do not wish to receive these, please check here: ____

I have received a copy of the Privacy Policies Notice. I have read the Notice and understand this authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the practitioner in writing.

Signature _____ Date _____

Print Name (Client or Personal Representative) _____

Relationship to Client and Description of Representative's Authority _____

Privacy Policies Notice—Please Keep for your records

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information
We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:
* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we ever sell or transfer our practice.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work‐related injuries or illness without regard to fault.
* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:
1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.
This notice remains in effect until it is replaced or amended by changes in the law.

Please keep for your records

Before your first appointment

Get a good night sleep
Eat lightly before and after a session
Don't come in if you're sick or have a contagious condition. Call to reschedule, please.
Be receptive and open to the experience

What to expect at your first appointment

No two bodies are alike so it's important to treat you as an individual. Your initial assessment is the key to long-term success. We follow the chain of muscular imbalances and dysfunction to its source.

Performing an assessment will help determine what type of care plan is appropriate. Existing conditions can often be improved simply with advice and recommendations, and more chronic problems can be treated following the assessment.

The care plan is contingent on agreed upon goals whether to relieve pain, restore lost mobility, or assist in injury recovery.

Postural assessments include:
* Examination of the alignment when the subject is standing
* Tests for flexibility and muscles length
* Tests for muscle strength as well as palpation techniques.

Assessment procedure observation is done while standing and then expanding this to include sitting and lying down.

Please note: postural assessment does not apply to all therapies

What to expect after:

Drink Plenty Of Water: Make sure to stay hydrated.

Give Yourself Some Time: You may not always feel better right away. Extremely tight muscles before a session can even make you feel even a little sorer right after. Take a nap if you can, take a bath after your massage in Epsom salt and baking soda, use an ice-pack on any specific areas that feel tender.

If you wake up the next morning feeling tired or even exhausted - just start drinking water until you feel better.

To follow after your appointment any suggested homework please adhere to this will reinforce results. For example active stretching exercises should be done to minimize soreness. If you have any questions or concerns call me 312-451-5771 or ask me during your session (it's OK to ask).

Don't Quit Just Because You Feel Better: Prevention is always better than treatment and a maintenance plan can keep you feeling good. Regular clients tend to report better results than those that just go in when they absolutely have to.

Treat it as you would any other activity that can help your well-being. Rather than considering it a pampering luxury, make it a part of your new healthier lifestyle!