Meridian Health Solutions Massage Intake Form – New Patient Date:________________

Name:____ Date of Birth:______________ Age: __________

Address (Street, City, Zip):____

Phone: (cell)_____________________ (other)___________________ Email: __________________________________

Gender: _______________________________ Preferred Pronouns: ____

Circle One: single partnered married polyamorous separated divorced widowed other: ________________

Occupation: ________________________Name of Spouse/Partner or Parent (if child): ___________________________

Emergency contact (name): ______________________________________ (phone): _____________________________

How did you learn about our office? ____

Which of the following types of treatment have you experienced before? **Circle all that apply:**

Acupuncture Herbal Medicine Chiropractic Massage Functional Medicine Dietary Consultation Homeopathy

The following information can affect how your massage session is performed. Please check YES or NO, and elaborate as needed.

Yes___ No___ Are you on prescription blood thinners?

Yes___ No___ Do you bruise easily?

Yes___ No___ Do you have any clotting disorders?

Yes___ No___ Do you have high or low blood pressure? High or low: __________

Yes___ No___ Do you have vascular problems such as deep vein thrombosis/DVT?

Yes___ No___ Do you have a history of cellulitis?

Yes___ No___ Do you have any skin conditions that the therapist should know about?

Yes___ No___ Are there any other health issues that require special care in your massage session?

Please say more about any of the above items that need elaboration:

____

____

____

Meridian Health Solutions Pain Assessment Form Patient ID:______(office use only)

Which Diagnostic studies have been done to evaluate your pain? (Circle all that apply and bring copies of the reports or films if applicable)

- MRI
- CT Scan
- X-Ray
- EMG/Nerve conduction studies
- Bone Scan
- Blood Tests
- Other: ______________________________

Which treatments have been done for your pain? (circle all that apply)

- Injection Treatments
- Chiropractic
- Massage
- Physical Therapy
- Surgical Procedures: ______________________
  ____
- Other: ___________________________________

WHERE is your pain? Left/Right sided, or both? ____

WHEN did your pain begin?____

HOW did your pain begin?____

What makes your pain WORSE?____

What makes your pain BETTER?____

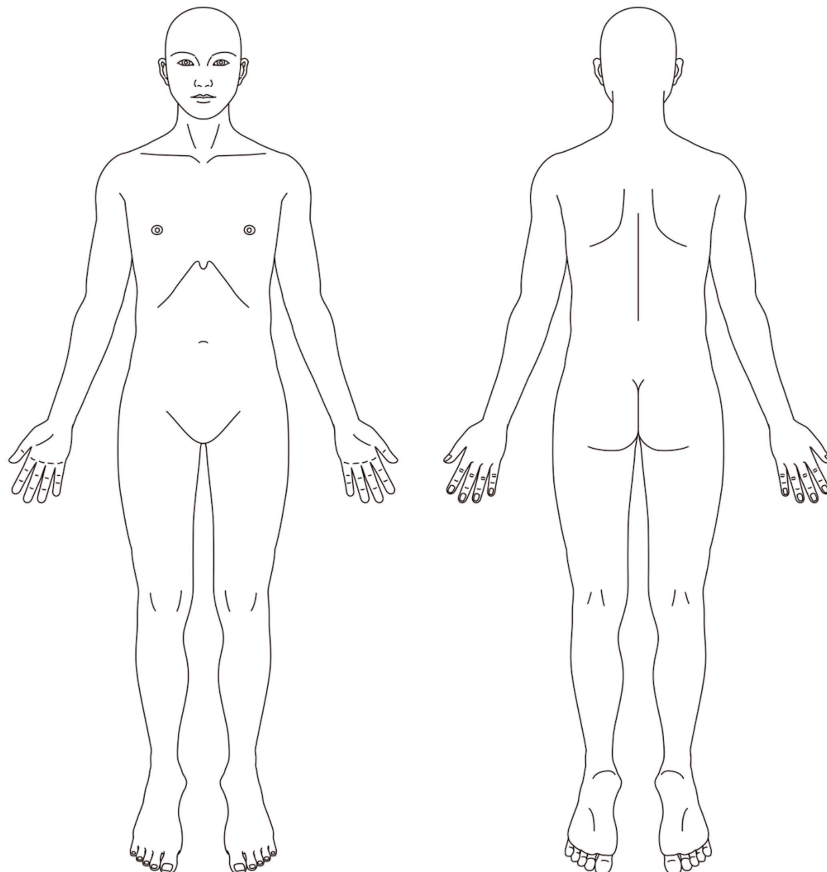
How does the pain affect your daily life?____

How does your pain CHANGE with time? ____

What does your pain feel like? (circle all that apply)
Warm. Hot. Cold. Sharp. Dull. Burning. Electricity. Stabbing. Tingling. Throbbing. Pounding. Crushing. Pulling. Cramping. Unbearable. Penetrating. Aching. Sore. Heavy. Tender. Blinding. Annoying. Agonizing. Tight. Numb. Squeezing. Other:____

Circle your areas of pain.
Rate the pain severity 0-10,
10 = highest pain.

Please note anything else you'd like for us to know about your pain:



Signatures for Meridian Health Solutions
Consent Form, Office Policies, HIPAA Privacy Policy, Confidentiality, and Email Permissions

After you read our Office Forms and Policies, please *initial* each item below, and *sign* at bottom of the form.

1. _______ I acknowledge that I was shown and have read a copy of the Consent Form from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

2. _______ I acknowledge that I was shown and have read a copy of the Office Policies from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

3. _______ I acknowledge that I was shown and have read a copy of the HIPAA Privacy Policy from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

4. _______ Confidentiality and Virtual Assistants: I acknowledge that Virtual Assistants such as Siri, Alexa, and Google Assistant are not confidential nor HIPAA-compliant. Thus, my confidentiality may be compromised by the presence of my own or other peoples' cell phones in the MHS office. I will minimize the problem by putting my cell phone in Airplane mode, turning it off, or disabling the virtual assistant before entering the treatment area.

5. Email and Texting Permission: MHS does not operate on a secure email or text platform, but we use email and text for ease and convenience. If you want to communicate with us via email and/or text, check the specific boxes below for which you provide consent. You may opt out at any time. MSG + data rates may apply.

   ___ I authorize MHS to use scheduling software that sends me automatic scheduling emails and/or texts.

   ___ I authorize MHS to text me regarding scheduling and non-medical communication.

   ___ I authorize MHS to email me regarding my medical care and questions.

   ___ I authorize MHS to email me periodic announcements such as the annual olive oil sale or clinic news updates (we do not bombard you; we send about 6 mass emails per year).

   I wish to receive communication at the following:

____ _______________________________

Email address Phone number

_______________________________________ _______________________________________

Patient's Full Name (please print) Signature of Patient or Responsible Party/Guardian

____

Date