WELCOME TO MYO PAIN CENTER OC
Standard Intake Form
Stand 09/2022

You have been referred to us by your physical therapist, doctor, friend or internet. We do our best to provide the professional services you seek and deserve to become pain free. All treatments take place in a safe and ethical space.

What to expect on your first visit?

Your first appointment consists of reviewing patient history form, postural evaluation, pain mapping, range of motion assessment and trigger point therapy. During the intake interview you can ask questions, discuss your general concerns and expectations, go over policy, determine the course of the treatment, setting goals, designing a treatment and self-care plan, and getting to know each other. <u>All new patients bring the following to their first appointment.</u>

- Read, complete and bring Patient-History to your first appointment
- bring copies of other useful documents such as X-rays, reports or MRI
- Bring comfortable underclothes such as a bathing suit, shorts or running pants for evaluation, assessment and treatment.
- If possible a doctor's prescription or referral with diagnosis

If you have any questions please feel free to ask. I am looking forward to work with you.

Sincerely,

Carlos Messerschmidt, LMT, CMTPT, NCTMB

MYO PAIN CENTER OC - CLIENT INFORMATION

Please print clearly

Name_____ **Phone** *(H)* _____ *(C)* _____

Address_____ **Apt#**_____ **EMAIL** _____

City_____**State**_____**Zip**_____

Occupation_____ **Date of Birth** _____**Referred by** _____

How did you find us? _____

Why do you seek treatment?_____

What are your goals for treatment with me? ▫ relaxation, ▫ stress-reduction, ▫ pain relief, ▫ Other_____

When did your discomfort begin and how did it first happen? _____

How would you describe your pain/symptoms? ▫ aching, ▫ dull, ▫ sharp, ▫ burning, ▫ tingling, ▫ stinging, ▫ numb, ▫ no pain, ▫ Other_____

Do you experience your condition: ▫ constant, ▫ on/off, ▫ mornings, ▫ evenings

What movement/action causes immediate pain?_____

Do you exercise? ▫ yes ▫ no **What type of exercise do you do?**_____

Please indicate areas of your body where you are experiencing pain, tension, soreness, stiffness or discomfort, even if you are not seeking treatment for it:

▫ Head	▫ Chest	▫ Sacrum	▫ Knees	▫ Arms	▫ Other_____
▫ Neck	▫ Upper Back	▫ Buttocks	▫ Legs/Calves	▫ Elbow	_____
▫ Jaw	▫ Middle Back	▫ Hips	▫ Ankles	▫ Wrist/Fingers	_____
▫ Shoulders	▫ Lower Back	▫ Thighs	▫ Feet	▫ Abdomen	_____

Please answer the following questions by circling the appropriate answer

Have you had a professional massage before?	**Yes**	**No**	**Please explain YES answers**
Have you ever had surgery?	**Yes**	**No**	
Do you have any spinal problems?	**Yes**	**No**	
Are you pregnant?	**Yes**	**No**	
Do you wear contact lenses or dentures?	**Yes**	**No**	
Do you take any prescribed medication?	**Yes**	**No**	
Do you have chronic back pain?	**Yes**	**No**	
Do you have frequent headaches?	**Yes**	**No**	
Are you constantly tired?	**Yes**	**No**	
Do you have any heart problems?	**Yes**	**No**	
Do you have high blood pressure?	**Yes**	**No**	
Do you have varicose veins?	**Yes**	**No**	
Do you have any blood clots?	**Yes**	**No**	
Have you ever been treated for cancer?	**Yes**	**No**	
Did your treatment include removal, radiation or testing of Lymph nodes? Chemotherapy?	**Yes**	**No**	

Have you ever suffered any acute injury?	**Yes**	**No**	
Do you have pain which radiates down legs or arms?	**Yes**	**No**	
Do you suffer from tension?	**Yes**	**No**	
Do you have chronic diarrhea?	**Yes**	**No**	
Do you have chronic constipation?	**Yes**	**No**	
Do you have arthritis?	**Yes**	**No**	

Please list any surgery or fractures_____

Disclosure

I, _____, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or pain/spasm, or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

- I understand that I am always in control of my body during my session and will feel free to comment on the comfort or discomfort of the amount of pressure or type of stroke used.
- I understand that I will be fully covered with a sheet or blanket all times and only the body part being worked on will be uncovered. I am aware that this is a non-sexual massage.
- I agree to pay by check, credit card or cash after the massage. If my check bounces, I agree to pay for the service fee, as well as any additional fines that therapist may incur as a result.
- If I am going to be late for an appointment, I agree to call as soon as possible and understand that my time may be shortened as a result.

Important Information

Pregnant women and individuals with high blood pressure, heart conditions, or under medical care should consult a physician before scheduling a session.

Cancellation Policy

Please notify me at least 24 hours in advance if you need to cancel your appointment or you will be charged the full amount, see Client-patient policy.

_____

Client Signature date

_____

Therapist Signature date

CLIENT / PATIENT POLICY

Welcome to MYO PAIN CENTER OC. The purpose of this statement is to determine what is and what is not acceptable, and to establish professional boundaries, so please read the following carefully.

You have been referred to me by a friend, healthcare professional or by your treating physician. My goal is to provide the highest quality care (Trigger Point Therapy and Massage Therapy) to those who seek professional service for the relief of chronic pain. We perform only those services for which we are qualified. My practice does require an initial intake interview and the completion of patient history form. More details you will find on page two under procedures.

BUSINESS HOURS: Monday to Friday from 9am to 6pm. Last appointment is 5pm.
Saturday from 9am to 1 pm. The last appointment 12pm.
By appointment only.

FEE SCHEDULE: (October 2021)

Initial interview *includes* preparation*, evaluation, and therapy*		
Standard intake interview	75 minutes	$155
Comprehensive intake interview	90 minutes	$175

Treatment times include 10 min for preparation and approx. 50/80 minutes for treatment.

Trigger Point Therapy	60 minutes	$135
	90 minutes	$175
Therapeutic Massages		
Lymphatic Massage, Cupping, deep	60 minutes	$135
tissue, or Customized	90 minutes	$175
Swedish massage (Relaxation)	60 minutes	$125
	90 minutes	$165
Rosen Method Bodywork	60 minutes	$115
Rosen Method Movement	60 minutes	$15
Discount Cards for prepaid sessions		
Buy 5 sessions get one for free	60 minutes	$675
Buy 10 sessions get two for free	60 minutes	$1300
Buy 5 sessions get one for free	90 minutes	$875

PAYMENT:
The payment for all type of treatment is due at the time of service and can be paid by check, Visa/Master card or cash. A fee of $25 will be charged for returned checks.

REFUNDS: Massage cards and gift certificates are non-refundable, but you can transfer to someone you know or share it.

CANCELLATION POLICY :

If you are a cash patient, please notify us at least 24 hours prior to the appointment time to avoid a cancellation charge. A cancellation fee equal to 100 % of the scheduled service fee will be charged if a timely notice of cancellation is not received.

If you are a Workers Compensation patient, please notify us at least 24 hours in advance if you need to cancel your appointment. Missed appointments without 24 hours' notice for Workers Compensation patients will be reported to the treating physician and insurance company as patient non-compliance which could possibly jeopardize your right to therapy. A proper cancellation gives others in need the opportunity to be treated.

CONFIDENTIALITY:

Confidentiality is used to protect client and patient information. If it becomes necessary to share information about one's care with other professionals involved in their care or insurance companies paying the bill, my practice is required to attain permission to release medical information. Information about care and treatments are shared only if the client or patient signs a statement authorizing it.

IMPORTANT INFORMATION:

Pregnant women and individuals with high blood pressure, heart conditions, or under medical care should consult a physician before scheduling a session.

PROCEDURES:

Talking Hands offers a variety of services; therefore two types of initial intake interviews have been developed. They are different in duration and the initial evaluation/physical assessment is part of your first appointment. The ***standard intake interview*** is designed for a regular client who seeks treatment for acute symptoms, relaxation, nourishment, or stress reduction (75 min). Massage Therapy would be the modality to meet those needs. Symptoms are mild and usually tightness, stiffness or aching pain.

d acute and chronic pain patients, Worker's Compensation patients, and individuals with injuries who primarily seek treatment for pain relief. Trigger Point therapy is best suited for these problems. For those individuals a medical history sheet and a different evaluation need to be completed and the best approach in treatment has to be determined. Symptoms are dull ache, sharp pain, soreness, tingling, numbness, cold fingers or feeds, etc.

Stricter rules under the Telephone Consumer Protection Act (TCPA go into effect on Oct.16 2013. Myo Pain Center OC now must get permission in writing to send automated text messages to clients, even if you have an established business relationship.

I, …….. agree to receive text messages to this mobile phone numbers ( ) _____-_____ reminding me about my upcoming appointments with Myo Pain Center OC. I understand that SMS reminders are optional and that messages and Data rates may apply.

Please initial here: _____

I have read and understand the "Client/Patient Policy". Please initial here_____

Patient / Client signature _____Date_____

Therapist signature _____Date_____

MYO PAIN CENTER OC
Carlos Messerschmidt CMT, CMTPT, NCTMB
170 E 17th , Suite 211, Costa Mesa, CA 92627 Phone 949-413-1567

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

My office / practice is required to have permission to send progress reports to your doctor (s), other therapist (s) and your insurance company. Please sign your initials in the appropriate slots to grant it.
Thank you.

I hereby give permission for Carlos Messerschmidt to send a progress report to my physician:_____

I hereby give permission for Carlos Messerschmidt to send a progress report to my therapist: _____

I hereby give permission for Carlos Messerschmidt to send a progress report to my insurance:_____

I agree that all information contained in this medical history is true and complete:

Patient signature _____Date_____

Therapist's signature _____Date_____

CONSENT FOR EVALUATION AND TREATMENT

I, _____, understand that the treatments are given at MPC OC are for the purpose of relief from musculo-skeletal pain, tension and/ or spasm.

I understand that Carlos Messerschmidt LMT, CMTPT does not diagnose illness, disease, or any other physical or mental disorder.

Myofascial Trigger Point Therapy includes: manual trigger point therapy, myofascial stretching, corrective exercises, ergonomic and self-care training. It has been made clear to me that this myofascial therapy is not a substitute for medical examination and/or diagnosis and it is recommended that I see a physician for medical conditions revealed on the Medical History Form or any other physical ailments I may have.

I have stated all of my medical conditions and symptoms on the Medical History Form and take it upon myself to keep Carlos Messerschmidt LMT, CMTPT updated about my physical health.

Side effects from treatment may include bruising, muscle soreness, swelling or tenderness for a short time (usually no longer than 24-48 hours) after treatment. I understand that I can refuse treatment at any time.

By voluntarily signing below, I consent to treatment. I have been told about the risks and benefits of trigger point therapy and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Carlos Messerschmidt LMT, CMTPT.

I have read CLIENT / PATIENT POLICY above (page 4,5 and 6) and understand it.

Patient Signature_____ Date____/_____/_____