washington park CHIROPRACTIC

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Massage Intake Form

Name _____ Date _____

Address _____ Date of birth_____

City _____ State _____ Zip Code _____ Gender ❒ Male ❒ Female

Preferred Phone _____ Email Address _____

Emergency Contact _____ Relationship _____ Phone # _____

Who many we thank for referring you to our office? _____

Employer _____ Occupation _____

Hours of computer use daily? _____ Right or Left Handed?

Hours worked each week? _____ Driving? _____ On your feet? _____

Describe a typical work day _____

Reason for Today's Visit

Please rank your health concerns/recent injuries and rate their severity (on a scale from 1-10, 10 being the worst)

Severity 1-10

1. _____

2. _____

3. _____

4. _____

Please list any medications you are currently taking: _____

_____

Have you had any surgeries in the past 5 years?_____

Have you ever received a professional therapeutic massage before? Y/ N

If yes, how often do you receive massage? _____

What style/pressure do you prefer? _____

What areas would you like to focus on? _____

Are there any areas you would like to avoid? _____

Are you pregnant? Y / N

Are you breastfeeding? Y / N

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In the past 2 weeks have you suffered from:

- ☐ Contagious disease such as flu/cold/virus
- ☐ Cuts/ abrasions/ sores/ bruises
- ☐ Skin disease - ❒Psoriasis ❒ Eczema ❒Athlete's foot
- ☐ Sunburn
- ☐ New tattoo

In your lifetime have you suffered from the following:

- ☐ Aneurysm
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bells palsy
- ☐ Blood clots
- ☐ Cardiovascular conditions (thrombosis, phlebitis)
- ☐ Cancer If yes, type?_____ When? _____ Treatment received_____
- ☐ Diabetes
- ☐ Edema / swelling
- ☐ Epilepsy or Seizure disorder
- ☐ Heart problems (angina, pacemaker)
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Inflammation
- ☐ Osteoporosis
- ☐ Nervous/psychotic conditions
- ☐ Stroke
- ☐ Trapped or pinched nerves
- ☐ Varicose veins
- ☐ Undiagnosed lumps or bumps
- ☐ Undiagnosed pain
- ☐ Neuropathy

Any additional questions for the massage therapists? _____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X _____ _____

Signature of Patient (or guardian if minor) **Date**

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No-Show/Cancellation Policy

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible. Please observe our cancellation policy for chiropractic and massage appointments.

We require a minimum 24-hour notice to cancel or reschedule all massage and new patient chiropractic appointments. We also require at least 2 hours notice for regular chiropractic appointments.

Fees

Chiropractic: no-shows/late cancels will be billed $25 for the first missed appointment and full price for subsequent missed appointments.

Massage: no-shows/late cancels will be billed for half of the price of the massage for the first missed appointment and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

_____ _____

Patient's Name (print) Date

_____

Patient's Signature

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