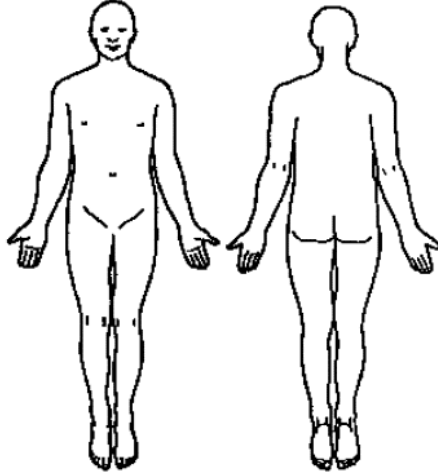
MASSAGE INTAKE

Patient Name____ Date___________________

CLIENT CONDITION

Please mark the areas you are having discomfort in:



When did your symptoms appear?____

What treatment have you already received for your condition?
□ Medication:________________ □ Physical Therapy □ Surgery
□ Chiropractic Care □ None □ Other:______________

Name and Address of doctor(s) or other practitioner(s) who have treated you for this condition:____
____

Type of Pain:
□ Sharp □ Dull □ Tingling □ Throbbing
□ Burning □ Cramps □ Stiffness □ Aching

How often do you have this pain?____
Is it Constant or does it come and go?_____________________________________

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform:
□ Sitting □ Standing □ Walking □ Bending □ Lying Down
□ Other:_____________________

HEALTH HISTORY

Please check the conditions or symptoms you currently have or have had in the past:
□ Anemia □ Cancer □ Hepatitis □ Multiple Sclerosis □ Sinus Problems
□ Appendicitis □ Diabetes □ Hernia □ Osteoporosis □ Stroke
□ Arthritis □ Emphysema □ Herpes □ Pacemaker □ Tendonitis
□ Asthma □ Epilepsy □ High Blood Pressure □ Pinched Nerve □ Tuberculosis
□ Blood Clots □ Fibromyalgia □ HIV/AIDS □ Pneumonia □ Tumors, Growths
□ Breathing Difficulty □ Fractures □ Polio □ Ulcers
□ Bronchitis □ Heart Disease □ Migraine Headaches □ Rheumatoid Arthritis
□ Whiplash □ Other:____

Medications:	Taking For:
Allergies:	
Vitamins/ Minerals	

Exercise: □ None □ Daily □ Moderate □ Heavy

Lifestyle: □ Smoking Packs/Day__________
□ Alcohol Drinks/Day_________
□ Caffeine/Coffee Cups/Day___________
□ High Stress Level

Are you pregnant? □ Yes □ No

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

____

____

Massage History

Have you ever received a professional massage ? □ Yes □ No

Why did you come in for our service? □ Relaxation □ Pain □ Therapy □ Other

What results would you like to achieve?____

____

Please note any areas of your body that you prefer not to be massaged..__________________________

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. I understand that it is my responsibility to inform my health care provider if ever I have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

I authorize 360 Chiropractic to share my personal information only with entities/persons directly related to my health care and insurance/payment needs. 360 Chiropractic will ask for my written permission for any other disclosure of my personal information. I understand that a fee applies for copying of my personal health information/ records set by state regulators annually.

I understand and agree that I am responsible for full payment for the massage services provided to the extent that such sums are not paid by the insurance company and/ or attorney. I understand that these fees are not negotiable since they are not payable at the time of service, but held as a courtesy.

_________________________________ __________________

Signature of Patient or Guardian Date

Massage Cancellation Policy

Thank you for choosing 360 Chiropractic as your massage provider! All massage appointments are reserved especially for you, so we require that any cancellations or rescheduling be done with at least 24 hours' notice. If our office is closed, please leave a message so we can assist you as soon as we return. **Reminder calls are a courtesy provided by our office; however, you are responsible for keeping track of your scheduled appointment.**

Please plan to arrive 10 minutes prior to your massage as your arrival time will determine the length of treatment which will end as originally scheduled. If you will be late to your scheduled appointment, please call with your estimated arrival time so we can determine whether we can accommodate your massage. Massage fees will remain unchanged regardless of treatment time.

If an appointment is missed or cancelled without 24 hours' notice, you will be charged a missed/cancelation fee outlined below. This fee is due upon notice and further massages will not be scheduled until the fee is paid. We reserve the right to refuse massage service. ***Please note:*** *Insurance companies/ Third Party payers do not pay for fees for missed services.*

Missed Massage Fees

30 Minute Massage	$30.00
60 Minute Massage	$50.00

____ _________________

Signature Date

____

Print Name