MIDDENDORF CHIROPRACTIC & MASSAGE THERAPY

2021 Southeast Sedgwick Road, Suite 1 Port Orchard, WA 98366

Phone: (360) 871-5200 Fax: (360) 871-5350

CONFIDENTIAL CLIENT INTAKE FORM

Colitis/Bone Disease Cancer Thrombosis/Embolism Numbness in Arms/Legs Ovarian/Menstrual Problems Leg Pain Tendonitis/Bursitis Bone/Joint Disorders Dislocations Irregular Sleep Patterns Phlebitis/Varicose Veins Fatigue Respiratory/Lung Problems Depression Sciatica/Lumbago Anxiety/Nervousness	Name:		Date:	
Marital Status: () Single () Married () Divorced Email Address:	Address:	City:	State:	Zip:
Marital Status: () Single () Married () Divorced Email Address:	Home #:	Cell #:	Work #	·
Please list major illnesses, surgeries, or hospitalizations in the last 5 years: Please list any prior injuries still affecting you: Please list any medications you are currently taking: On a 0-10 pain scale (with 10 being the worst) what would you rate your pain? Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illne Please circle any of the following conditions you have or had: Heart Problems Skin Disorders Chonic Illness/Pain Migraines/Headaches Ovarian/Menstrual Problems Dislocations Dislocations Dislocations Please Indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	DOB:	Case Type (Circle): L&I P	I Insurance Cash First	Massage (ever) (Y / N)
Please list any prior injuries still affecting you: Please list any medications you are currently taking: On a 0-10 pain scale (with 10 being the worst) what would you rate your pain? Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illin Please circle any of the following conditions you have or had: Heart Problems Skin Disorders Diabetes Colitis/Bone Disease Ovarian/Menstrual Problems Dislocations Respiratory/Lung Problems Neck/Spinal Problems Neck/Spinal Problems Neck/Spinal Problems Please indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	Marital Status: () Single ()	Married () Divorced Email	Address:	(Sec.)
Please list any prior injuries still affecting you: Please list any medications you are currently taking: On a 0-10 pain scale (with 10 being the worst) what would you rate your pain? Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illing Please circle any of the following conditions you have or had: Heart Problems Skin Disorders Diabetes Obstrain/Menstrual Problems Constipation Constipation Chronic Illness/Pain Migraines/Headaches Arthritis/Rheumatism Colitis/Bone Disease Ovarian/Menstrual Problems Dislocations Respiratory/Lung Problems Neck/Spinal Problems Neck/Spinal Problems Please indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	Insurance Carrier:	Claim/ID#:	Occı	ipation:
Please list any medications you are currently taking: On a 0-10 pain scale (with 10 being the worst) what would you rate your pain? Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illine Please circle any of the following conditions you have or had: Heart Problems Constipation Please Chronic Illness/Pain High/Low Blood Pressure Osteoporosis Migraines/Headaches Colitis/Bone Disease Cancer Thrombosis/Embolism Numbness in Arms/Legs Dovarian/Menstrual Problems Leg Pain Tendonitis/Bursitis Plebitis/Varicose Veins Plebitis/Varicose Veins Sciatica/Lumbago Arxiety/Nervousness Neck/Spinal Problems Muscle Problems Back Pain Sciatica/Lumbago Significant Weight Loss Please indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	Please list major illnesses,	surgeries, or hospitalizations in	the last 5 years:	
Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illine Please circle any of the following conditions you have or had: Heart Problems Constipation Please Circle any of the following conditions you have or had: Heart Problems Constipation Please Circle any of the following conditions you have or had: Constipation Drug/Alcohol Addiction High/Low Blood Pressure Arthritis/Rheumatism Arthritis/Rheumatism Thrombosis/Embolism Tendonitis/Bursitis Dislocations Depression Depression Phlebitis/Varicose Veins Sciatica/Lumbago Sciatica/Lumbago Significant Weight Loss Please indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	Please list any prior injuri	es still affecting you:		
Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illine Please circle any of the following conditions you have or had: Heart Problems Constipation Please Circle any of the following conditions you have or had: Heart Problems Constipation Please Circle any of the following conditions you have or had: Constipation Drug/Alcohol Addiction High/Low Blood Pressure Arthritis/Rheumatism Arthritis/Rheumatism Thrombosis/Embolism Tendonitis/Bursitis Dislocations Depression Depression Phlebitis/Varicose Veins Sciatica/Lumbago Sciatica/Lumbago Significant Weight Loss Please indicate where you're experiencing pain or discomfort by marking/circling the diagram below: The above information is true and accurate to the best of my knowledge. Unless covered by a prearranged insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.	Please list any medication	s you are currently taking:		
Heart Problems Skin Disorders Diabetes Corronic Illness/Pain Migraines/Headaches Ovarian/Menstrual Problems Neck/Spinal Problems Neck/Spinal Problems Neck/Spinal Problems Neck/Spinal Problems Thrombosis/Demo Disace Neck/Spinal Problems Neck	On a 0-10 pain scale (wit	th 10 being the worst) what wo	uld you rate your pain? _	
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insurance claim, I agree to pay for my massage treatment by cash, card, or check at the time of treatment.				
Signature: Date:				
	Signature:	,	Date:	

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CANCELLATION POLICY

At Middendorf Chiropractic we understand that unanticipated events arise in everyone's life that may cause them to cancel or alter a scheduled massage therapy appointment. *In our desire to be effective and fair to all of our clients, and out of consideration for our therapists' time*, we have adopted the following policies effective 11/16/2017 (Revised 9/3/2024):

- A 24- hour advance notice is required when cancelling or rescheduling a massage appointment.
- If a patient is unable to give us a minimum of 24-hour advance notice they will be charged a cancellation fee of \$45.00 due before their next scheduled massage. This fee will not be billed to any insurance companies, and payment of this fee is the patient's responsibility.
- Patients who either forget their scheduled appointment or consciously forgo their appointment for whatever reason will be considered a "no-show". They will be charged the same \$45.00 cancellation fee also due before their next scheduled massage. This fee will not be billed to any insurance companies, and payment of this fee is the patient's responsibility.

I,, have read and	_, have read and fully understand the requirements of this cancellation policy.			
Patient eignature	Date			