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

Name: ______________________________ Date: ____________________

Address: ____________________ City: ______________ State: ________ Zip: __________

Home #: ________________ Cell #: __________________ Work #: ______________

DOB: ___________ |Case Type (Circle): L&I PI Insurance Cash | First Massage *(ever)* (Y / N)

Marital Status: () Single () Married () Divorced Email Address: ______________________

Insurance Carrier: ______________Claim/ID#: ______________Occupation: ____________

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: ______________________________

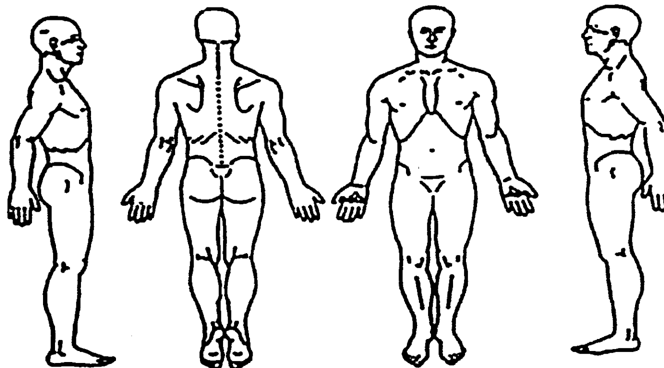
On a 0-10 pain scale (with 10 being the worst) what would you rate your pain? ________________

Please circle all that apply: Contact Lenses Fever Pregnancy Acute Inflammation Localized Infection Communicable Illness

Please circle any of the following conditions you have or had:

Heart Problems	Constipation	Drug/Alcohol Addiction	Hay Fever/Allergies
Skin Disorders	Chronic Illness/Pain	High/Low Blood Pressure	Osteoporosis
Diabetes	Migraines/Headaches	Arthritis/Rheumatism	Kidney/Bladder Ailment
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
Neck/Spinal Problems	Muscle Problems	Back Pain	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.

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 fully understand the requirements of this cancellation policy.

Patient signature: ________________________________ **Date:** ____________________