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? (Y / N)

Insurance Carrier: _____ Claim/ID#: _____

Please list major illnesses, surgeries, or hospitalizations in the last 5 years: _____

_____

Please list any prior injuries still affecting you: _____

_____

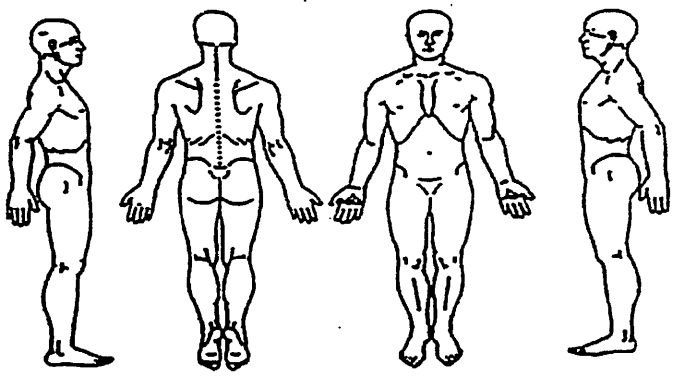
Please list any medications you are currently taking: _____

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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Robin McNeil, LMP

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 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:

- 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 $35.00 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 $35.00 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: _____