

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: _____

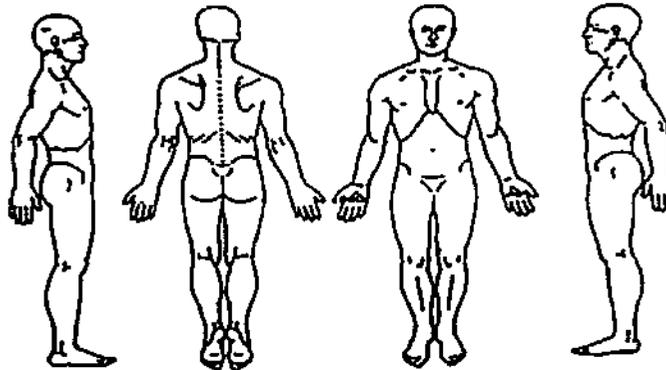
Please list any medications you are currently taking: _____

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 \$50.00 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 \$50.00 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: _____