Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

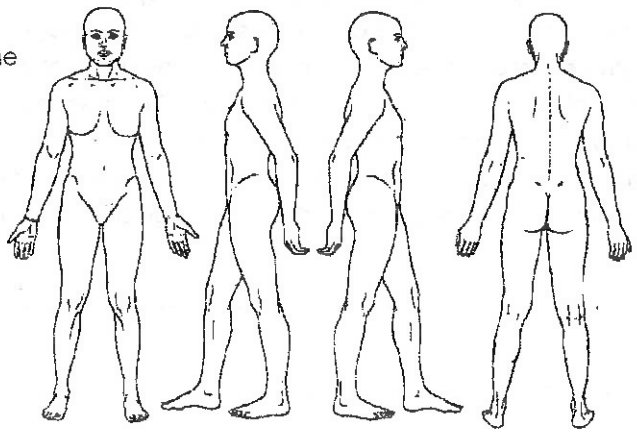
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy If yes, how many months?
( ) atherosclerosis	

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Assignment of Benefits Form

Financial Responsibility

I have requested services from EDC Family Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. I understand that insurance coverage is a supplement to help pay for care, not a sole means of achieving it. Regardless of what my insurance policy says they will pay, all services/products rendered are my responsibility. I understand that payments paid are applied first to any products/care not covered by insurance then to any deductible, co-pays, etc. Balances greater than 90 days past due may be sent to collections and a collection agency fee (minimum of 50% of the balance) will be added to the balance due.

Authorization of Release Information

You, EDC Family Chiropractic, and Dr. Jeremy Book, are authorized by me to release any information you deem appropriate concerning my care to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at EDC Family Chiropractic by me. I also request payment of government benefits either to myself or to the party who accepts assignment on the HFCA-1500 form used to file my insurance.

Assignment of Benefits

I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by EDC Family Chiropractic for services described on the said HFCA-1500 form.
I authorize and assign the direct payment to EDC Family Chiropractic of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.
Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient/Responsible Party Signature: _____ Date:_____

Witness: _____ Date: _____

Massage Scheduling Policy

Due to the timing reserved for a massage and blocking of the massage room per each individual client and only that client EDC Family Chiropractic has a scheduling policy.

A minimum of 24-hours
is required to cancel or reschedule a massage appointment. Please keep in mind we are only open till noon on Friday so if you have a Monday appointment you are required to let us know on the Friday to ensure you do not get charged for the missed or canceled appointment.

- We do understand emergencies happen so the first time you do not show up or cancel without proper notice there will not be a charge unless otherwise decided by the owner.
- After the first cancellation or reschedule without proper notice you will be charged for the missed appointment and required to pay in advance for all massages. If you cancel with proper notice the payment can be used towards future appointments. If the proper notice is not provided the fee will be FORFEITED.

Patient Signature: _____

Date:_____