Ballard Chiropractic – Massage Intake Form

9015 Holman Rd NW, Suite 3 • Seattle, WA 98117 • (206) 782-8500 • (206) 784-4020 fax

Name:_____ Age:_____ Today's Date _____

Address:_____ Birth Date:_____ ❑ M ❑ F ❑ NB

City:_____ State:_____ Zip Code:_____

Contact Preference: ☐ Cell: _____ ☐ Bus: _____

☐ Home: _____ ☐ Email: _____

Employer:_____ Your Title:_____

❑ Married ❑ Single ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated Number of Children _____

InsuranceCompany:_____

Insurance billing will be handled out of this office. If you have an insurance card, please let us know and we will see that your insurance company receives the proper information to process your claims. For worker's injuries an Accident Form must be completed. Motor vehicle accident cases will be discussed in depth due to the complexity of such cases. An auto accident questionnaire must also be completed. We look forward to serving you!

TODAY'S ISSUES

Primary area of concern: _____

Date of Onset: _____ Cause, if known: _____

_____

Other Health Care Providers seen for condition: _____

HEALTH HISTORY

Any accidents, injuries, or surgeries: Yes: ____ No: ____

More than 5 years ago: _____

Less than 5 years ago: _____

Are you currently receiving medical treatment or are you under a doctor's care?

Yes: _____ No: _____

If yes, please explain: _____

Are you taking any medications? Yes: _____ No: _____

If yes, please describe: _____

Are you currently experiencing any of the following conditions?

___ Heart Problems	___ Infection/Inflammation	___ Skin Problems
___ Aneurysms	___ Cancer	___ Gout
___ Herniated Discs	___ Tumors	___ Pain
___ Contagious Disease	___ Ring Worm	___ Varicose Veins

Comments: _____

MASSAGE HISTORY

Have you received massage before? Yes: ____ No: ____ Date of last massage _____

Do you have a preference of a massage style, any likes or dislikes?

_____

How often and in what way do you exercise?

_____

Where do you tend to hold stress in your body?

_____

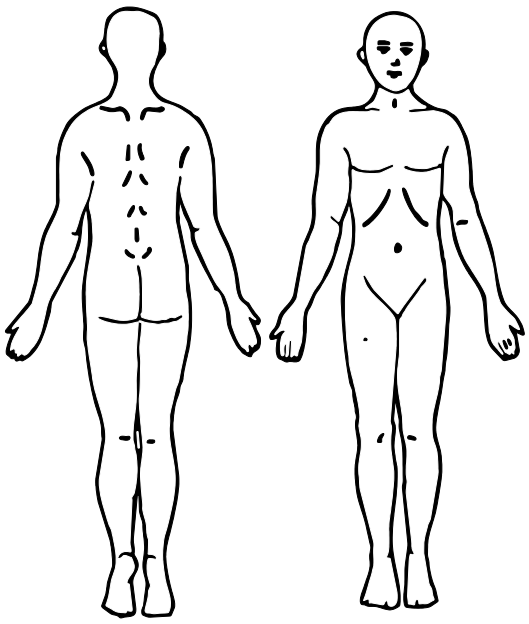
What areas do you want to assure are addressed today?

_____

Are there any areas we need to avoid or that are especially sensitive to touch?

_____

Do you wear contact lenses? Yes: _____ No: _____



Please mark any problem areas on the diagrams

I understand that massage practitioners do not diagnose illness or disease, prescribe any medical treatment, pharmaceuticals or perform manipulations. Most insurance companies cover massage therapy, however, they can deny this benefit for many reasons. In the case my insurance denies massage therapy, I understand any balances owed become my sole responsibility to pay.

I agree to the policy that a fee for service may be charged in the event of cancellation with less than 24 hours notice. In addition, I agree to update my practitioner of any changes in my health status.

Client's Signature: X_____ **Date:** _____

Ballard Chiropractic Clinic, PS

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MASSAGE THERAPY CANCELLATION POLICY

- Please give 24-hours notice if you need to cancel your appointment.
- If you do not give us notification to cancel your appointment, we may be unable to fill that time slot with other patient's needing care. Out of consideration for others, please call, text or email us to cancel your appointment if you can't make it.
- **$50.00** will be charged for missed appointments without 24-hours notice. However, this charge will be waived should your time slot later be filled.
- Insurance companies do not cover missed appointments and it is illegal for us to bill them for appointments the client did not receive.

Your signature below indicates you agree and will abide by this clinic policy.

Client Signature Date