**Balance**Chiropractic
7165 E University Dr. Suite 102
Mesa, AZ  85207 480.830.0175

# Massage Intake Form

**Name**__________________________________________________ **Date**______________________________
**Address**_____________________________________________ **City**_____________________ **State**_____
**Date of Birth**____________________________**Age**________ **Phone**______________________________
**Email Address**___________________________________________________________________________
**Employer**________________________________________________________________________________
**Emergency Contact**_______________________________________ **Phone**_________________________
**Referred By** _______________________________________________________________________________

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

**Smoking Status (circle one):** Every day/ Occasionally/ Former/ Never
**Smoking Start Date (Optional):**_____________ **How Many Packs per Day:**_________

**Gender:** Male Female

**Race (circle one):** American Indian or Alaskan Native/ Asian/ Black or African American/ White(Caucasian)/ Native Hawaiian or Pacific Islander/ Decline to Answer

**Ethnicity (circle one):** Hispanic or Latino/ Not Hispanic or Latino/ Decline to Answer

**Are you currently taking any medication?** ________Yes ________No
If Yes, please list:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Do you have any drug allergies?** ________Yes ________No
If Yes, please list:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Are you allergic to any lotions or oils?** ________Yes ________No
If Yes, please list:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Area(s) of concern:** ______________________________________________________________________

# INFORMED CONSENT/FINANCIAL POLICY

When a patient seeks massage health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be use to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo massage care after being advised of the known benefits, risks and alternatives.

**Terms and Definitions:**
**Massage:** The rubbing, or kneading, of muscles and joints of the body to relieve pain and stress.
**Structural Integration:** System oriented work addressing fascia (connective tissues) and full-body patterns.

I understand that a massage therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. If I become uncomfortable for any reason I may ask the therapist to end the massage session, and they will end the session. I understand that the massage therapist may end the session for any inappropriate behavior.

For Insurance/Personal Injury Cases:
I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Balance Chiropractic will bill my insurance, as a courtesy, but cannot guarantee that my carrier will pay my claim. I understand that if my claim is denied by my carrier, the obligation for payment is mine. Balance Chiropractic will supply patients with statements, reports, or other documents, as requested, to help them receive reimbursement from a third party.

I have read, fully understand, and questions have been answered regarding, the above and accept massage therapy on this basis.

______________________________________________ ____________________
(signature) (date)

**Balance Chiropractic accepts: Cash, Personal Checks, Visa, MasterCard, Discover, and American Express**

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**Consent for a minor child:** I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive massage therapy.

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The information on our website will help you *Get Well and Stay Well.*

Please check box if you would like to be enrolled to receive our monthly e-newsletter ☐

Email address: ________________________________________________