Sound Body Health & Chiropractic

Cancellation / Missed Appointment Policy

In order to serve you better, please provide us with at least 24 hours notice if you will be unable to attend your appointment. This advance notice allows us to provide other patients awaiting an appointment the opportunity to receive care.

If you miss an appointment without providing at least **4 hours** notice you will be responsible for the following charges:

- **$25 - No show chiropractic appointment**
- **$25 – No show functional medicine appointment**
- **$35 – No show half hour massage appointment**
- **$65 – No show 1 hour massage appointment**

I, (print your name or name of responsible party here) _____ agree to pay the appropriate cancellation fee if I fail to notify Sound Body Health & Chiropractic at least 4 hours in advance of my appointment.

_____ _____

Patient Signature **Date**

_____ _____

Signature of responsible party (if patient is a minor) **Date**

12792 W. Alameda Pkwy, Ste. E, Lakewood, CO 80228 Phone: 303-953-5200 Fax: 3035937454

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement(s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

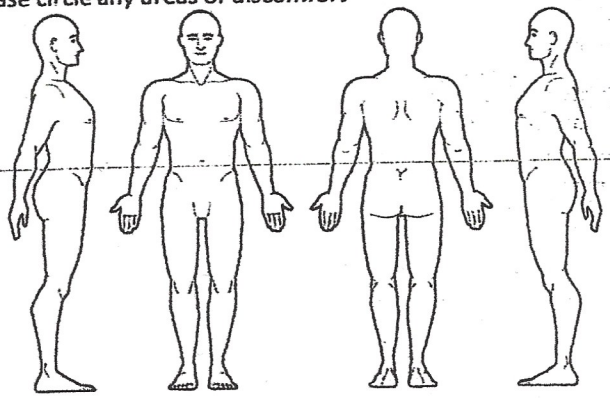
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____