GO HEALTH CHIROPRACTIC MASSAGE

MASSAGE OFFICE POLICY

The following is a summary of our center's policies.

We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health.

We are happy to answer any questions that you have.

Massage Policies:

- Cancellation Policy:
  - If you cannot make your appointment we ask that you please contact our office by phone or email us with 24 hours in advance to cancel.
  - If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'

- No Show Policy:
  - If you fail to cancel your appointment according to the 'Cancellation Policy' you are considered a 'No Show.' And when you fail to redeem this appointment time you will be responsible for payment of that massage in the following manner: your gift certificate will be redeemed, you can take care of the payment at your next appointment, or a statement of the missed appointment will be sent to the address on file.

Refusal of Service Policy

We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Massage Office Policy,' I herby agree to the terms and conditions outlined above.

Patient Printed Name: _____

Patient/Guardian Signature: _____

Date: _____

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MASSAGE INFORMATION & HISTORY

Please complete this form completely and to the best of your ability.

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D

Address: _____ City: _____

State: _____ Zip: _____ *E-mail: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Wellness Information:

Have you ever had a professional massage or bodywork? ☐ Yes ☐ No If so, when? _____

Have you received Chiropractic care? ☐ Yes ☐ No Are you currently under Chiropractic Care? ☐ Yes ☐ No

Do you take time to relax? ☐ Yes ☐ No Do you feel you are under stress? ☐ Yes ☐ No

What goals / benefits do you wish to achieve from massage therapy? _____

Are you currently physically active? ☐ Yes ☐ No What activities & how often? _____

Injury History:

☐ Auto Accident/Year(s): _____ ☐ Injury at Work/Year(s): _____ ☐ Fall or Other Injury/Year(s): _____ ☐ Sports Injury/Year(s): _____

Please describe any injuries / conditions: _____

How long has this condition existed? _____ Have you had this condition in the past? _____

Programs:

Are you enrolled in a Federally Funded Insurance Program? ☐ Yes ☐ No

Medical Information:

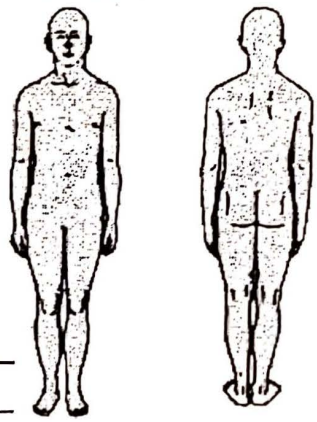
Are you currently taking medication? ☐ Yes ☐ No Types: _____

Do you have any allergies? ☐ Yes ☐ No Please List: _____

Are you currently under the care of a physician, physical therapist, or psychologist? ☐ Yes ☐ No If so, Why? _____

Please check all conditions that apply & mark areas you would like addressed on the diagrams: *Please Mark Below:*

☐ Acne	☐ AIDS/HIV	☐ Anemia	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Athlete's foot	☐ Back Pain
☐ Blood Clots	☐ Broken Bones	☐ Burns	☐ Cancer/Tumors
☐ Bronchitis	☐ Circulatory Problems	☐ Constipation	☐ Cuts or Sores
☐ Diabetes	☐ Diarrhea	☐ Dizziness	☐ Epilepsy
☐ Fatigue	☐ Fractures	☐ Headaches	☐ Hernia
☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol	☐ Insomnia
☐ Joint Disease	☐ Kidney Disease	☐ Liver Disorder	☐ Lung Disease
☐ Nervousness	☐ Paralyses	☐ Plates / Screws	☐ Pregnant
☐ Rash	☐ Sinusitis	☐ Skin Problems	☐ Spinal Problems



How did you hear about our Massage Therapists? _____

I understand that a massage therapist provides the massage/bodywork I receive for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes will be adjusted to my level of comfort. I further understand that massage and bodywork 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 of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. Lastly, I authorize instructor observation and demonstration of techniques if so warranted.

Client Signature: _____ **Date:** _____

Consent to Treatment of Minor: My signature below hereby authorizes a Certified Massage Therapist to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: _____ **Date:** _____

*Providing your e-mail allows Massage Advantage to e-mail you promotions and coupons accordingly. E-mail will not be sold to third parties or for solicitation. Massage Advantage Center. 0810. Massage Intake Form.