



**MESSAGE CLIENT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Best Phone number C/H/W: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

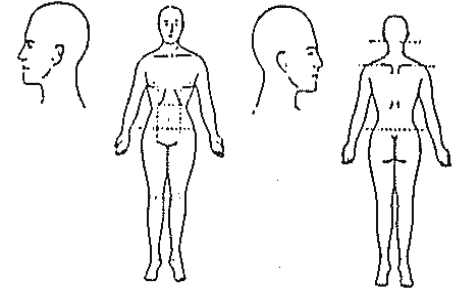
Who May We Thank For Referring You? \_\_\_\_\_

Emergency Contact, Name & #: \_\_\_\_\_

How often do you receive massage? \_\_\_\_\_

**Please indicate on the diagram where your symptoms are.**

Please describe your current health problem: \_\_\_\_\_



What are your treatment or healthcare goals? \_\_\_\_\_

Do you experience any chronic conditions: **Yes / NO** If yes please explain: \_\_\_\_\_

Is this condition a result of an injury?: **Yes / NO** If yes please explain: \_\_\_\_\_

How long has this been occurring? \_\_\_\_\_

When does it feel better or worse? \_\_\_\_\_

Any area you prefer not to be massaged (Feet/face/etc.)? \_\_\_\_\_

**If you answer yes to any of the following questions, please explain as clearly as possible.**

**Yes No** Do you suffer from any skin problems or allergies? Explain \_\_\_\_\_

**Yes No** Do you or have you ever had heart problems? Explain \_\_\_\_\_

**Yes No** Do you have high or low blood pressure? Please list medications \_\_\_\_\_

**Yes No** Do you have or have you ever had cancer? \_\_\_\_\_

**Yes No** Do you have varicose veins, thromboplebitis? **Please circle**

**Yes No** Do you have arthritis, osteoarthritis or Rheumatoid arthritis? **Please circle**

**Yes No** Do you have diabetes? If yes is it controlled? \_\_\_\_\_

**Yes No** Do you experience prolonged episodes of depression or other emotions? \_\_\_\_\_

**Yes No** Are you experiencing any sleep disorders at this time?

**Yes No** Do you have asthma? \_\_\_\_\_

**Yes No** Do you suffer from epilepsy or seizures? \_\_\_\_\_

**Yes No** Have you ever had surgery? Explain: \_\_\_\_\_

**If Yes; Date of surgery?** \_\_\_\_\_

**Yes No** Are you pregnant? What trimester? **Please circle: 1 2 3**

**Yes No** Do you have any medical condition we should know about? \_\_\_\_\_

**Yes No** Are you taking any prescription or over the counter medication including Tylenol or Ibuprofen? Include dosage and for what condition: \_\_\_\_\_

How much water do you drink a day? \_\_\_\_\_ Oz.

How would you describe your overall level of stress? High \_\_\_\_\_ Medium \_\_\_\_\_ Low \_\_\_\_\_

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_



# Massage Policy



Health isn't everything, but everything is nothing without health...

## Appointments

Specific times will be made for massage therapy. Only appointments that have been made either in person or on the phone with a member of the clinic will be honored.

If you are unable to keep an appointment time for any reason, we request that you call immediately to reschedule your visit. If you are going to be late, please call so the therapist can be notified.

Massage Therapy appointments will be 25 or 55 minutes in length to allow for patients to dress and the therapist to prepare the room for the next client.

## Cancellation policy

There will be a **\$30** charge for all missed half-hour appointments, a **\$40** charge for all missed one hour appointments, and a **\$50** charge for all missed one and a half hour appointments including those not cancelled with 24 hours' notice. This charge is **Not** billable to insurance and must be paid out of pocket at the time of cancellation.

## Financial

All fees charged will be according to the Family Chiropractic fee schedule. Any questions regarding charges or insurance assignment should be directed to clinic staff members and **not** Licensed Massage Therapists.

All fees will be collected either before or immediately after the massage appointments.

In the event the client is late for the appointment, they are responsible for the cost of the full scheduled amount of time.

**By signing below you agree and understand the appointment, financial and cancellation policy.**

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness signature (Office Staff):** \_\_\_\_\_

### All parents/legal guardians of individuals under 18 years of age:

\* You are invited to be present during your child's massage session should you desire.

I consent to my child \_\_\_\_\_ to receive therapeutic massage.

**Parent/ Legal Guardian Name (please print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_