Massage Therapy Client Intake Form

PERSONAL INFORMATION

Name _____

Date of Birth _____

Address_____

City/State/Zip_____

Email _____

Emergency Contact _____

Relationship _____

Phone _____

Phone: Day _____

Evening _____

Would you like appointment Reminders? ☐Yes ☐No

Email ☐ Text ☐ Name of cell carrier_____

Occupation _____

Employer _____

Primary Physician _____

How did you hear about us? _____

MEDICAL INFORMATION

Are you taking any medication? ☐Yes ☐No

Please list name and use:_____

_____

Are you currently pregnant? ☐Yes ☐No

How far along?_____

Do you suffer from chronic pain? ☐Yes ☐No

Please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries or recent surgeries? ☐Yes ☐No

Please list _____

Please indicate any of the following that apply.

- ☐ Cancer
- ☐ Allergies
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Seizures
- ☐ Neuropathy
- ☐ Headaches/Migraines
- ☐ Recent Vaccines/ Injection
- ☐ Tendonitis/Bursitis
- ☐ Fibromyalgia
- ☐ Recent Cold/Flu
- ☐ Contagious Conditions
- ☐ High/Low Blood Pressure
- ☐ Stroke, Blood Clots

Please list any other conditions not mentioned 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? ☐Yes ☐No

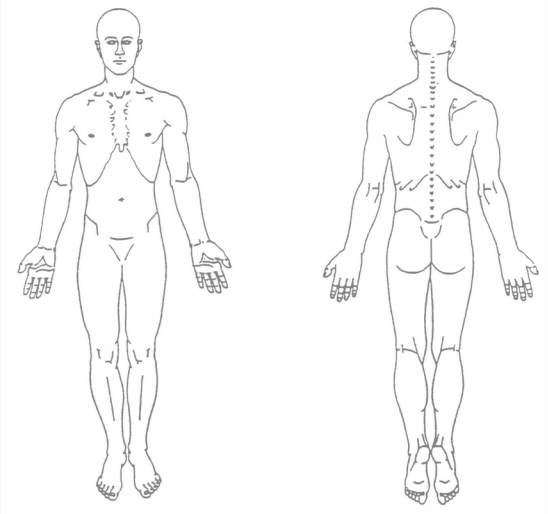
Please explain _____

Are there any areas (feet, face abdomen, etc.) **you do not want massaged?** ☐Yes ☐No

Please explain_____

Major complaint? _____

Have you experienced cupping before? ☐Yes ☐No



Please circle any areas of discomfort.

Please read the following carefully and sign and date below:

I,_____ ,understand that massage/bodywork is intended to enhance relaxation, reduced pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me.

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Care Provider for any condition I may have.

I am aware the massage therapist cannot diagnose medical issues/disease/disorders, and spinal manipulations are not part of massage therapy. I have informed the massage therapist of all known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I also understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session and I will be liable for the payment of the scheduled appointment.

I give my permission for my Licensed Massage Therapist, to contact my primary care provider at any time to discuss proper treatment.

Cancellations and Policies: (initial down below)

At Tusken Chiropractic we understand that unanticipated events occur in everyone's life. However, out of respect for our therapists and other patients, we ask that you do your very best to not cancel appointments at the last minute or not show up for your scheduled appointment.

_____**Tardy Policy:** As a courtesy to our patients, if you arrive late, your session will be shortened to the remainder of your original scheduled appointment. If you arrive more than 15 minutes late you will be asked to reschedule (therapists may choose to accommodate for the change if they are able). The first offense will be forgiven, but any following will be charged 100% of the scheduled service price. If more than 3 visits are missed or tardy, advanced payment will be required.

_____**Cancellation Policy:** You may cancel or reschedule you appointment without charge prior to 24 hours in advance or by the end of business hours (6:00pm) the day before your appointment. If you cancel or reschedule with less than the aforementioned notice or via voicemail after closing the business day preceding your appointment, you will be charged 100% of the scheduled price.

_____**No Show Policy:** Out of consideration if a patient does not show up for a scheduled appointment and does not provide any type of advanced notice, the patient will be charged the full price of the service.

There will be a $25.00 charge for any returned checks.

HIPAA Notice: I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. I have been provided an opportunity to review the Notice of Privacy Practices and agree to their terms.

Patient's Signature: (parent if minor)_____
Date: _____