Ballard Chiropractic – Massage Intake Form

9015 Holman Rd NW, Suite 3 • Seattle, WA 98117 • (206) 782-8500 • (206) 784-4020 fax

Name:____ Age:_______ Today's Date ____________________

Address:____ Birth Date:______________ ❑ M ❑ F

City:____ State:_____________ Zip Code:___________________

Contact Preference: ☐ Cell: ______________________________ ☐ Bus: _________________________________

☐ Home: ____________________________ ☐ Email: ____________________________

Employer:_______________________________________ Your Title:___________________________________

❑ Married ❑ Single ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated Number of Children _____

InsuranceCompany:____

Insurance billing will be handled out of this office. If you have an insurance card, please let us know and we will see that your insurance company receives the proper information to process your claims. For worker's injuries an Accident Form must be completed. Motor vehicle accident cases will be discussed in depth due to the complexity of such cases. An auto accident questionnaire must also be completed. We look forward to serving you!

TODAY'S ISSUES

Primary area of concern: ____

Date of Onset: _________________ Cause, if known: ____

____

Other Health Care Providers seen for condition: ____

HEALTH HISTORY

Any accidents, injuries, or surgeries: Yes: ____ No: ____

More than 5 years ago: ____

Less than 5 years ago: ____

Are you currently receiving medical treatment or are you under a doctor's care?

Yes: ______ No: ______

If yes, please explain: ____

Are you taking any medications? Yes: _____ No: _____

If yes, please describe: ____

Are you currently experiencing any of the following conditions?

___ Heart Problems ___ Infection/Inflammation ___ Skin Problems

___ Aneurysms ___ Cancer ___ Gout

___ Herniated Discs ___ Tumors ___ Pain

___ Contagious Disease ___ Ring Worm ___ Varicose Veins

Comments: ____

MASSAGE HISTORY

Have you received massage before? Yes: ____ No: ____ Date of last massage ____________________

Do you have a preference of a massage style, any likes or dislikes?

____

How often and in what way do you exercise?

____

Where do you tend to hold stress in your body?

____

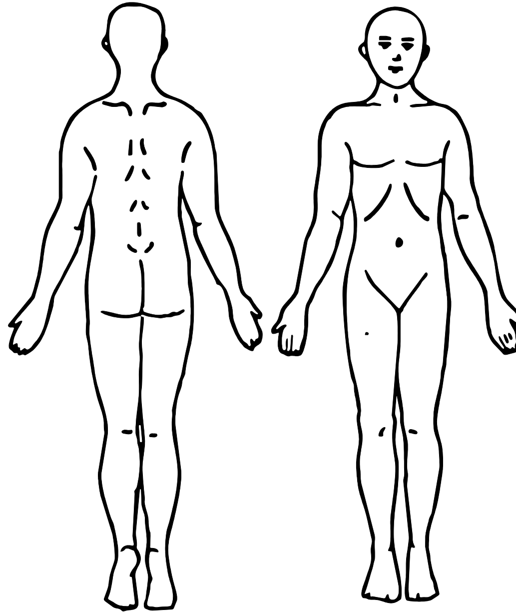
What areas do you want to assure are addressed today?

____

Are there any areas we need to avoid or that are especially sensitive to touch?

____

Do you wear contact lenses? Yes: _____ No: _____



Please mark any problem areas on the diagrams

I understand that massage practitioners do not diagnose illness or disease, prescribe any medical treatment, pharmaceuticals, or perform manipulations. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I agree to the policy that the fee for services may be charged in the event of cancellation with less than 24 hours notice. I agree to update my practitioner of any changes in my health status.

Client's Signature: X____ **Date:** ____________________

Ballard Chiropractic Clinic, PS

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MASSAGE THERAPY CANCELLATION POLICY

- Please give 24-hours notice if you need to cancel your appointment.
- If you do not give us notification to cancel your appointment, we may be unable to fill that time slot with other patient's needing care. Out of consideration for others, please call to cancel your appointment if you can't make it.
- **$50.00** will be charged for missed appointments without 24-hours notice. However, this charge will be waived should your time slot later be filled.
- Insurance companies do not cover missed appointments and it is illegal for us to bill them for appointments the client did not receive.

Your signature below indicates you agree and will abide by this clinic policy.

____
Client Signature