

PRECISE CHIROPRACTIC MASSAGE CLIENT INTAKE FORM

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone_(Home) _____ (Cell) _____ Preferred Contact # is Home or Cell? _____

Email address _____

Referred by _____

In case of an emergency _____ Phone _____

Occupation _____ Male _____ Female _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated (not allowed). A referral from your primary care provider may be required prior to any service being provided.

Have you ever experienced a professional massage or bodywork session? Y N How recently? _____

What are your massage or bodywork goals? _____

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

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you frequently suffer from stress? | <input type="checkbox"/> YES <input type="checkbox"/> NO Do you bruise easily? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have diabetes? | <input type="checkbox"/> YES <input type="checkbox"/> NO Any broken bones in the past five years? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you experience frequent headaches? | <input type="checkbox"/> YES <input type="checkbox"/> NO Any injuries in the last five years? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Are you pregnant? | <input type="checkbox"/> YES <input type="checkbox"/> NO Any accidents in the last five years? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you suffer from arthritis? Where? _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO Are you wearing contact lenses? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have cardiac or circulatory problems? | <input type="checkbox"/> YES <input type="checkbox"/> NO Are you wearing dentures? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have high blood pressure? | <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have varicose veins? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Are you taking high blood pressure medication? | <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have osteoporosis? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you suffer from epilepsy or seizures? | <input type="checkbox"/> YES <input type="checkbox"/> NO Do you suffer from joint swelling? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have any contagious diseases? | <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have any autoimmune diseases? |

YES NO Do you have any allergies. If yes please explain: _____

YES NO Have you ever had surgery? Please explain: _____

YES NO Any other medical condition? Please explain: _____

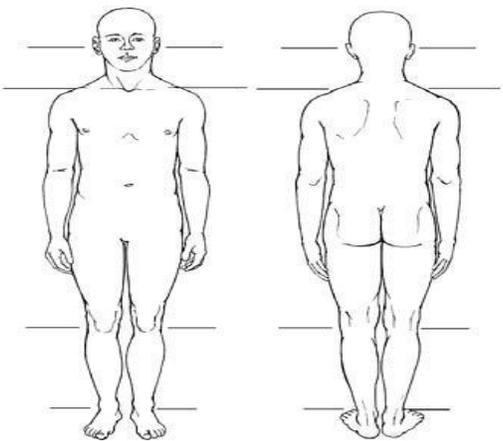
YES NO Are you taking any medication? Please list, include OTC's. _____

YES NO Are you sensitive to touch or pressure in any area? _____

YES NO Do you suffer from back or neck pain? _____

On a scale of 1 (low) to 10 (high) please rate your pain today _____

Please describe your pain, using the body charts to aid you. Do you have any sharp or stabbing pain? YES NO



Identify CURRENT symptomatic areas in your body by marking letters on the figures. Use the letters provided in the key to identify the symptoms you are feeling today.

KEY:

P = pain or tenderness

S = joint or muscle stiffness

N= numbness or tingling

***Cancellation Policy**

We understand that unanticipated events happen occasionally in everyone’s life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists’ time, we have adopted the following policies:

***24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged for the full session.

***Arriving late**

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the “full” session.**

*Out of respect and consideration to your therapist and other clients, **please** plan accordingly and be on time.*

<p>*Massage Rates: 60 minutes: 65.00 90 minutes: 95.00</p>

Payment is due at time of service. For your convenience we accept cash, check, Visa, and MasterCard.

DISCLAIMER: Precise Chiropractic is not responsible for lost or stolen property, nor will Precise Chiropractic be held liable for any injury or condition that arises from application of massage despite completion of this form. I understand and voluntarily accept the risks associated with massage. This form is intended as an assessment tool only and serves as a guide for the application of massage, not for medical treatment or medical assessment. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Draping will be used during this session. Only the body area being worked on will be uncovered. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examinations, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialists 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 course of 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 medical 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 practitioner’s part should I fail to do so. I understand that all massage therapists of Precise Chiropractic are licensed professionals and that by law they have the right to refuse service on any client at any time, if they feel as though their well being is compromised. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session and I will be liable for payment for the scheduled appointment. This agreement together with Precise Chiropractic’s wellness plan rules and regulations, constitute the entire agreement between you and us and cannot be amended, except in writing by both parties. Myself and/or any of my heirs, executors, representatives, or assignees hereby release Precise Chiropractic from all claims or liabilities for personal injury or property loss or damages of any kind sustained while on the premises. I agree that this application and waiver is in effect for all massages and will not expire unless specifically requested by either party.

Client signature _____ Date _____

Practitioner’s signature _____ Date _____

***Consent to Treatment of Minor:** By my signature below I hereby authorize the massage therapists of Precise Chiropractic to administer massage/bodywork to my child or dependent _____ as they deem necessary.

Signature of Parent or Guardian _____ Date _____

***CHIROPRACTIC PATIENTS:**

NUCCA and massage work great together! You’ll receive the greatest benefits by scheduling your massage on the same day as your adjustment. We suggest furthering your health care benefits by allowing **the chiropractors of Precise Chiropractic** and **the massage therapists of Precise Chiropractic** to work as a team; discussing your care as professionally dictated.

I give permission to the chiropractors and massage therapists of Precise Chiropractic to discuss my case in order to further my health care benefits.

Signature/Date _____