Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

Email _____ DOB _____ Occupation _____

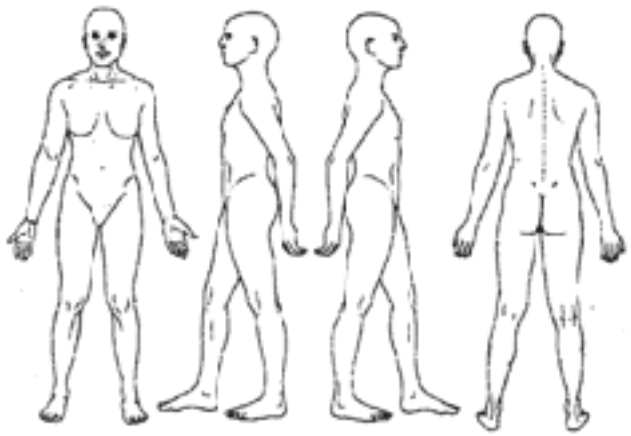
Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain _____
3. Do you have sensitive skin/any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain _____
4. Are you wearing: contact lenses ( ) dentures ( ) a hearing aid ( )?
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____
6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____
7. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other: _____
8. Is there a particular area where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please identify _____
9. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain _____

10. Circle any areas you would like the massage therapist to concentrate on during the session:



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Medical History:

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No
    If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis/deep vein thrombosis/blood clots
( ) open sores or wounds	( ) respiratory problems
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) edema/inflammation	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer or tumors
( ) sprains/strains	( ) diabetes
( ) current fever or infection	( ) decreased sensation or numbness/tingling
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy If yes, how many months? _____
( ) atherosclerosis	( ) removed or radiated lymph nodes
( ) heart, liver, kidney, or urinary issues	( ) other:

Please explain any condition that you have marked above: _____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

NEWTON CHIROPRACTIC & WELLNESS CENTRE

PLEASE READ CAREFULLY BEFORE SIGNING – THANK YOU

PAYMENT POLICY

• All persons are required to pay-in-full for services rendered at time of visit unless otherwise arranged. You may pay by cash, check or charge.

• If you would like us to accept insurance assignment (accept your insurance as payment), you must first apply through our finance department. Once you have been accepted for assignment, as a courtesy to you we will submit your bills directly to your insurance company(s).

• If you would like us to assist you in verifying whether your insurance will cover some or all of your care here, please show the receptionist your health insurance card. The finance department will then advise you of your options.

• You are responsible for your deductible, co-payments and any unpaid balance on your account if your insurance company, for any reason, does not honor their commitment to you.

• We will assist you to understand your policy limitations, but we suggest that you communicate directly with your current carrier with any questions or concerns you have regarding your specific policy, including chiropractic benefits.

• Wellness Care Packages and Care Plans have been created to provide you with an affordable payment option. Please keep track of how many visits you have used.

CANCELLATION POLICY - (PLEASE READ CAREFULLY)

Please notify us as soon as possible if you are unable to keep your appointment. Our answering machine is on 24-hours a day.

Please help us to serve all members by providing us as much notice as possible.

Initials:	*Minimum 24-hour notice prior to a Chiropractic Appointment – Otherwise a **$25 fee** will be charged to your account.
_____	*Minimum 48-hour notice prior to an Acupuncture or Massage Appointment – Otherwise an **$89** fee will be charged to your account. **($125 fee** will be charged for a 90-minute Massage appointment).

** Please note - We will do our best to fill your missed appointment. You can also give your space to a friend or family member.*

It is our commitment to serve as many people as we can, providing the highest quality care at an affordable rate.

In order to keep this commitment to the members of our practice, strict enforcement of the cancellation policy is necessary.

I have read, understand, and agree to the above policies.

_____ _____

Patient's signature ***Date***

I hereby assign any insurance payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance.

_____ _____

Patient's signature ***Date***

NEWTON CHIROPRACTIC & WELLNESS CENTRE

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Newton Chiropractic Centre / Newton Chiropractic & Wellness Centre.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):_____

Signature:_____Date:_/_/____