Today's Date: _____

Massage Client Intake Form

Name: _____ Date of Birth: _____

Address: _____State: _____ Zip: _____

Phone: (_____)_____Email: _____

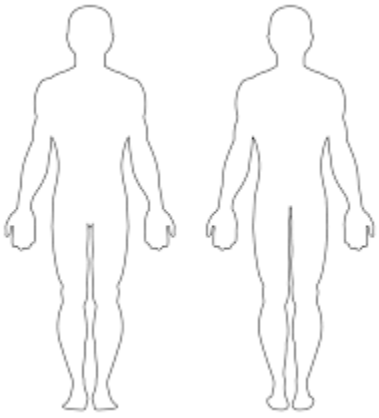
Occupation: _____Emergency Contact/Phone: _____

Referred By: ____Dr. Chapman ____Website/Facebook ____Person: _____

Have you experienced a professional massage/body work session before? ___No ___Yes/When?_____

General & Medical Information-Please check all that apply and note approximate date of occurrence.

	Abdominal Pain		Accident Date:
	Arthritis		Broken Bones
	Cancer:		Decrease Range of Motion
	Current Treatment		Disk Problems
	Diabetes		High Blood Pressure
	Heart Problems		Low Back Pain
	Joint Ache		Neck Pain
	Mid Back Pain		Osteoporosis
	Nervous Tension		Stiffness
	Sprains		Surgery
	Stroke		Varicose Veins
	Upper Back Pain		Pregnant
	Whiplash		Stabbing Pain
	Numbness		Headaches
	Contagious Disease		Stress
	Easily Bruised		Seizures
	Soreness		Shoulder Pain
	Arm Pain		Other:
	Allergies:		Medications:



Front View Back View

Please indicate your area(s) of pain and discomfort above.

Is there anything else that your therapist needs to be aware of? ____ No ____ Yes, please explain:

_____

I realize that this massage is being given for the health of my body and mind. This can include stress reduction, relief from muscular tension, spasm or pain, or increased circulation or energy flow. I agree to communicate with my massage therapist any time I feel that my well-being is compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage is not a substitute for medical examinations or diagnosis. I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status prior to future massages. **Initial:** _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for Align Chiropractic. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment or payment for services. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health care information. The Statement of Privacy Practices is also posted in the facility. Align Chiropractic reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me. **Initial:** _____

With the current Statement of Privacy Practices, is there anyone that we can communicate that you are being seen in this office? ____Yes: (name)_____or _____No

Missed Appointment Policy: 24 hour notice is required to cancel or reschedule appointments.
Align Chiropractic reserves the right to charge a $50 missed appointment fee if you fail to give proper notice. If you **no show** an appointment, Align Chiropractic reserves the right to charge the full amount of the missed massage appointment. **Initial:** _____

Signature: _____ Date: _____

To ensure the pleasure of your massage, please indicate if you prefer conversation or silence during your massage. (Check below)

_____Conversation

_____Silence

**If you choose to tip your massage therapist, please do NOT include this tip with the payment of your massage.

Thank you for your time and cooperation.

Relax and enjoy your massage!