Pure Health Chiropractic

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked 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 or sensitivities? ☐ yes ☐ no

Please explain _____

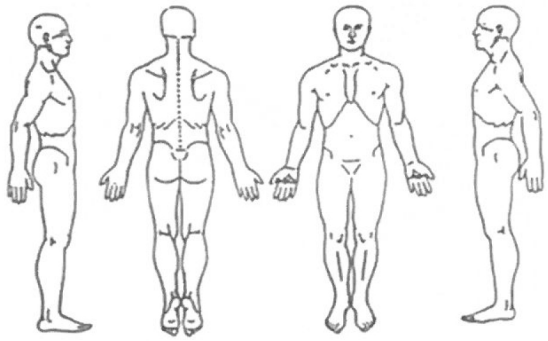
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Pure Health Chiropractic
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TWENTY-FOUR HOUR CANCELLATION POLICY FOR MASSAGE THERAPY CLIENTS

We value each of you as individuals and welcome the responsibility and privilege of caring for and supporting you as health care professionals.

Our goal is for each client to be seen and treated in a timely and efficient manner. With that as our focus, we want to remind everyone of our Clinic policy concerning cancelled appointments.

- Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session.
- You may cancel your appointment without charge with a minimum of 24 hours' notice.
- Same day cancellations will be charged 50% of the scheduled service price.
- If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

We appreciate your patronage and look forward to treating you in a timely and efficient manner.

By signing below I acknowledge that I have read and agree to this cancellation policy.

Name: _____ Date: _____
(Please Print)

Signature: _____