

# WARWICK CHIROPRACTIC AND MASSAGE ~ MASSAGE INTAKE FORM

client signature \_\_\_\_\_

## personal information

name \_\_\_\_\_ date of birth \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_  
home phone \_\_\_\_\_ cell phone \_\_\_\_\_  
work phone \_\_\_\_\_ ext. \_\_\_\_\_  
email \_\_\_\_\_  
occupation \_\_\_\_\_  
employer \_\_\_\_\_  
employer address \_\_\_\_\_  
marital status \_\_\_\_\_ if married, spouses name \_\_\_\_\_  
referred by \_\_\_\_\_  
emergency contact name (relationship) \_\_\_\_\_ emergency contact phone \_\_\_\_\_  
physician's name \_\_\_\_\_ physician's phone \_\_\_\_\_

## massage experience

Have you had a professional massage before?  Yes  No  
If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?  
\_\_\_\_\_  
How long have you been receiving massage therapy? \_\_\_\_\_  
Frequency of massages? \_\_\_\_\_  
What are your goals for treatment? \_\_\_\_\_  
\_\_\_\_\_

## health history

### Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

### Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

### Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify: \_\_\_\_\_
- Sinus Problems

### Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

### Reproductive

- Pregnant, stage \_\_\_\_\_
- Ovarian/Menstrual Problems
- Prostate

date of initial visit \_\_\_\_\_

## current health

Reason for initial visit \_\_\_\_\_  
Height & weight \_\_\_\_\_  
Do you exercise regularly and/or participate in any sports?  Y  N  
If yes, what kind of exercise/sports? \_\_\_\_\_  
Do you perform any repetitive movement in your work, sports or hobby?  Y  N  
If yes, describe \_\_\_\_\_  
Do you sit for long hours at a workstation, computer or driving?  Y  N  
If yes, describe \_\_\_\_\_  
Do you experience stress in your work, family, or other aspect of your life?  Y  N  
If yes, describe \_\_\_\_\_  
Are you experiencing tension, stiffness, discomfort or pain?  Y  N  
If yes, describe \_\_\_\_\_  
Have you recently had an injury, surgery, or areas of inflammation?  Y  N  
If yes, describe \_\_\_\_\_  
Do you have sensitive skin?  Y  N  
Do you have any allergies to oils, lotions or ointments?  Y  N  
If yes, please explain \_\_\_\_\_  
List any medications you are currently taking \_\_\_\_\_  
List any known allergies \_\_\_\_\_

### Skin

- Allergies, specify: \_\_\_\_\_
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

### Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

### Psychological

- Anxiety/Stress Syndrome
- Depression

### Other

- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed: \_\_\_\_\_

Please explain any of the conditions that you have marked above : \_\_\_\_\_

## WARWICK CHIROPRACTIC MASSAGE AGREEMENT AND POLICIES

**CLIENT AGREEMENT** – It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical or chiropractic care, medical or chiropractic examination or diagnosis. I have stated all medical / chiropractic conditions that I am aware of and will inform my practitioner of any changes in my health status.

**CANCELLATION POLICY** – We respectfully ask that you provide us with a 24 hour notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointment without providing a 24 hour notice, we are often unable to fill that appointment time. This is an inconvenience to your therapist and also means our other clients miss the chance to receive services they need. For this reason, you will be charged a \$50 cancellation fee. We require a credit card number to be given to charge cancellation fees as needed.

CREDIT CARD NUMBER \_\_\_\_\_ EXP DATE \_\_\_\_\_ CV CODE \_\_\_\_\_ ZIP \_\_\_\_\_

We understand that emergencies can arise and illnesses do occur at inappropriate times. If you have a fever, known infection, or have experienced vomiting or diarrhea within 24 hours prior to your appointment time, we request that you cancel your appointment. Inclement weather may also result in the need for late cancellations. We will do our best to give advanced notice if we are closing or need to cancel due to bad weather, and we ask you to do the same. Please do not risk your own safety trying to make your appointment. Late cancellation due to emergency, illness, or inclement weather will generally not result in any missed session charges, but this is determined on a case by case basis by the office director.

**LATE ARRIVAL POLICY** – We request that you arrive 10-15 minutes early to your appointment time to fill out required paperwork as well as answer any intake questions your massage therapist may have. We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so that we can do our best to accommodate you. Specific appointment times are reserved for each client, so often times we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full service fees will be charged even when sessions are shortened due to late arrival. In return, we will do our best to be on time, and if we are unable to do so, we will add time to your session to make up for our late arrival or adjust the service charge accordingly. Patients who are chiropractic and massage: we coordinate our chiropractic and massage schedules very precisely. Dr. Warwick will know if / when you are getting a massage, and as long as you are on time for both appointments, you will receive the full treatment needed and scheduled from Dr. Warwick and also our massage therapists.

**INAPPROPRIATE BEHAVIOR POLICY** – Massage therapy is for therapeutic and relaxation purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your massage session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited, we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity, and you will be treated the same in return.

**ASSIGNMENT OF BENEFITS** – I am responsible for all charges for all service provided. In the event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. I authorize and direct payment of insurance benefits to Warwick Chiropractic for services billed by any massage therapists employed by Warwick Chiropractic.

**RELEASE OF RECORDS** – I authorize the release of records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance companies for the purposes of processing my claims.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME