GET WELL
CHIROPRACTIC

Case Number

Today's Date

CA DC

Tell Us About You

Title:____ First:_____ MI:____ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

City:_____ State:_____ Zip:_____

Primary Tel:_____-_____-_____ H / W / C Alt. Tel:_____-_____-_____ H / W / C

Email:_____ In which format do you prefer appointment reminders?

❒ Text message—provider:_____ ❒ Email (above)

Whom may we thank for referring you?_____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____

Employment status: ❒ Full-time ❒ Part-time ❒ Not employed ❒ Self ❒ Retired

Occupation:_____ Employer:_____

Student: ❒ No ❒ Full-time ❒ Part-time School name:_____

Emergency Contact:_____ Phone:_____-_____-_____

Emergency contact is your: ❒ Spouse/partner ❒ Parent ❒ Other:_____

The following information will be used to help plan safe & effective massage sessions

Date of initial visit:_____

Have you had a professional massage before? ❒ No ❒ Yes—how often? _____

Do you have any difficulty lying on your front, back, or side? ❒ No ❒ Yes—explain _____

Do you have any allergies to oil, lotions, or ointments? ❒ No ❒ Yes—explain _____

Do you have sensitive skin? ❒ No ❒ Yes—explain _____

Are you wearing contact lenses ❒, dentures ❒, a hearing aid ❒?

Do you sit for long hours at a workstation, computer, or driving? ❒ No ❒ Yes

Do you perform any repetitive movement in your work, sports, or hobby? ❒ No ❒ Yes

Do you experience stress in your work, family, or other aspect of your life? ❒ No ❒ Yes—how has it affected your health? muscle tension ❒, anxiety ❒, insomnia ❒, irritability ❒, other ❒:_____

Is there a particular area of your body where you often experience tension, stiffness, pain, or other discomfort?
❒ No ❒ Yes—please identify _____

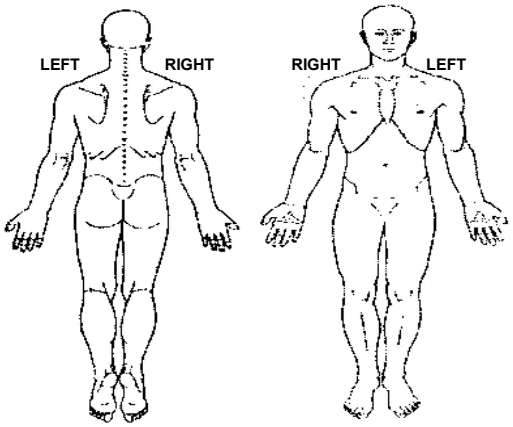
_____

Do you have any particular goals in mind for your massage sessions? ❒ No ❒ Yes—explain _____

_____

_____

Circle any specific areas on the diagram that you would like the massage therapist to concentrate on during your sessions.



Are you currently under medical supervision? ❒ No ❒ Yes—explain _____

_____

_____

Medical History

Do you see a chiropractor? ❒ No ❒ Yes—how often? _____

Are you currently taking any medications? ❒ No ❒ Yes—list _____

_____

Have you had a recent accident or injury? ❒ No ❒ Yes—explain (include dates)_____

_____

Have you had a recent fracture? ❒ No ❒ Yes—explain_____

Have you had a recent surgery? ❒ No ❒ Yes—explain (include dates)_____

_____

WOMEN ONLY: Are you pregnant? ❒ No ❒ Yes—how many months?_____

If no, are you currently trying to conceive? ❒ No ❒ Yes

Please mark whether you NOW HAVE (❍) or had IN THE PAST (❒) any of the following conditions/illnesses:

NOW HAVE / IN THE PAST		NOW HAVE / IN THE PAST		NOW HAVE / IN THE PAST	
❍	❒ Contagious skin condition	❍	❒ Circulatory disorder	❍	❒ Headaches/migraines
❍	❒ Open sores or wounds	❍	❒ Varicose veins	❍	❒ Cancer
❍	❒ Easy bruising	❍	❒ Atherosclerosis	❍	❒ Decreased sensation
❍	❒ Artificial joint	❍	❒ Phlebitis	❍	❒ Back/neck problems
❍	❒ Sprains/strains	❍	❒ Deep vein thrombosis (clots)	❍	❒ Fibromyalgia
❍	❒ Current fever	❍	❒ Joint disorder	❍	❒ TMJ
❍	❒ Swollen glands	❍	❒ Rheumatoid arthritis	❍	❒ Carpal tunnel syndrome
❍	❒ Allergies/sensitivity	❍	❒ Tendonitis	❍	❒ Tennis elbow
❍	❒ Heart condition	❍	❒ Osteoporosis	❍	❒ **No Conditions/Illnesses**
❍	❒ High or low blood pressure	❍	❒ Epilepsy		

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ❒ No ❒ Yes—_____

_____

_____

Massage Policies and Procedures

Appointments: Prepayment for your appointment is required to hold your time slot.

Cancellations: Cancellations or changes to your appointment must be done **24 hours prior to your appointment time.** All insurance and cash clients will be charged a "no show" fee if proper notice is not given. The fees are as follows: $21 for 30 minutes, $30 for 60 minutes, and $50 for 90 minutes.

Promptness: It is very important that you arrive on time for your appointment as the therapists are booked back to back and insurance is billed in 15 minute increments. If you are late your massage time will be reduced. If you are more than 15 minutes late your appointment will be cancelled and the proper fees will be accessed.

Payment: We accept cash, check, Visa, MasterCard, American Express & Discover. There is a $30.00 fee for all returned checks.

Gratuities: Gratuities are appreciated but are always at our client's discretion. Gratuities must be paid directly to the massage therapist through cash or check, or done at the front desk by credit card.

To help us ensure clarity of communication, please initial the following:

_____ I acknowledge and understand Get Well Chiropractic's Massage Policies and Procedures.

Draping will be used during the session, only the area being worked on will be uncovered. Clients ages 8-14 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

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 there shall be no liability on the therapist's part should I fail to do so.

Name of Patient: _____ Date:_____

Personal Representative: _____ Relationship:_____

Signature:_____ Case:_____