Avise Chiropractic Massage Intake

4017 A St SE B101 Auburn, WA 98002
253-939-8144 Phone/ 253-939-2289 Fax

Personal Information Date_____

Name_____ Date of Birth _____ Marital status S/ M / W / D

Address_____ City _____ State _____ Zip_____

Phone (Home) _____ (Cell) _____ Work_____

Email_____ Preferred method of contact H / C / W / Email

Health History

Have you ever received a professional massage? Y / N Date of last massage _____

Are you currently under the care of a health care practitioner? Y / N If yes, what for?

_____

When did your condition start? (Please give date if possible)_____

What event or action aggravated your complaint? _____

List current medications and purpose_____

List any injuries/ accidents/ illness still affecting you_____

_____

Surgeries (Please give dates if possible) _____

Please circle any of the following that you now have or have had

Musculoskeletal

Bone or joint disease

Tendonitis/ Bursitis

Arthritis/ Gout

Jaw pain/ TMJ

Lupus

Spinal Problems

Respiratory

Breathing difficulty/ Asthma

Emphysema

Sinus Problems

Circulatory

Heart Condition

Phlebitis/ Varicose Veins

Blood Clots

High/ low blood pressure

Lymph Edema

Thrombosis/ Embolism

Skin

Rashes

Athletes Foot

Herpes/ Cold sores

Allergies (Please specify) _____ Skin allergies (Please specify)_____

Nervous System

Shingles

Numbness/ Tingling

Pinched Nerve

Digestive

Irritable Bowel Syndrome

Ulcers

Crohn's Disease

Other

Cancer/ tumors

Bladder kidney ailment

Diabetes

Drug/ alcohol/ caffeine/ tobacco use

Chronic Fatigue or pain

Sleep disorders

Migraines/ headaches

Anxiety/ Stress

Depression

Reproduction

Pregnant: Y/ N Weeks_____

Ovarian/ menstruation problems

Prostate

Additional patient remarks/ comments:

_____

_____

_____

_____

_____

Office Policy

I have completed this form to the best of my knowledge and will inform the massage therapist of any changes to my physical health. I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical or emotional disorder, nor perform any spinal adjustment. I am responsible for consulting a Physician or Chiropractor for any physical ailments that I have. I understand that massage therapy is a therapeutic health aide and is non-sexual. I understand that if the massage therapist starts a session late, the time will be made up at the end of the massage hour if possible, or reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so that the person following me is not penalized.

_____ **I do** _____ **do not** consent to gluteal massage and understand that this consent may be retracted at any point during my treatment. I understand that I will only be undraped in accordance with both my comfort level and the draping policies set forth by Avise Chiropractic.

_____**I do** _____ **do not** consent to pectoral massage and understand that this consent may be retracted at any point during my treatment. I understand that I will only be undraped in accordance with both my comfort level and the draping policies set forth by Avise Chiropractic.

When arriving for your appointments, please go to the front desk and sign in. This will help us keep you on time to the appointed therapist. _____**INITIAL**

Financial Policy

I agree to give a 24- hour notice for a schedule session that I cannot keep. I am aware that I will be charged $35 for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule. _____INITIAL

All copayments, deductibles, and no insurance covered charges must be paid at time of service.
_____INITIAL

We will prepare and send all claims to your insurance on your behalf **_____INITIAL**

Insurance benefits quoted are not a guarantee of payment by my insurance company. I understand that I am responsible for all charges incurred with my provider
_____INITIAL

I have read and understand the Terms of Acceptance, Financial Policies and agree to the above terms. I also understand that the practice may amend the terms from time to time.

Signed _____ Date _____

Treatment of a Minor

I _____ parent of _____ have read and fully understand the terms above and hereby grant my permission for my child to receive massage therapy at Avise Chiropractic.

Signed _____ Date _____