

Name:	Today's Date:
Address:	City/State/Zip:
Home Phone:	Work Phone:
Cellular:	Email:
Birthday:	Social Security Number:
Occupation:	Employer:
Physician Name:	Physician Phone#:
Permission to consult with Physician?	Circle: YES NO
Emergency Contact Name:	Phone Number:

MESSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? **YES** **NO** If yes, frequency? Date of last massage:

What results do you want from your massage sessions?

Prioritize the areas of your body that you would prefer to be massaged:

Please circle the areas of your body that you give permission to receive massage:

- Back** **Legs** **Buttocks** **Arms** **Abdomen** **Chest** **Neck** **Head** **Face** **Feet**

Are you currently seeing a medical practitioner? **YES** **NO** Please explain if yes:

Are you currently seeing a psychotherapist or attending regular support group meetings? **YES** **NO** Please explain if yes:

List Stress Reduction/Exercise Activities and frequency:

List current medications/herbal supplements/vitamins, etc:

PREVIOUS HISTORY

Surgeries: (Include year and treatment received)

Accidents:

Please circle and/or explain further if you have any of the following:

		MUSCULO-SKELETAL
Bone or joint disease	Tendonitis	
Bursitis	Broken/Fractured bones	
Arthritis	Jaw pain/TMJ	
Sprains/Strains	Low Back/Hip/Leg pain	
Neck/Shoulder/Arm pain	Headaches/Head injuries	
Spasms/Cramp	Other	
Lupus		

		CIRCULATORY
Heart condition	Varicose veins	
High blood pressure	Blood clots	
Low blood pressure	Lymphedema	
Breathing difficulty	Sinus problems	
Other		

		SKIN
Allergies	Rashes	
Athletes foot	Warts	
Wounds/Scars	Other	

		DIGESTIVE
Constipation	Gas/Bloating	
Diverticulitis	Irritable Bowel Syndrome	
Other		

		NERVOUS SYSTEM
Herpes/shingles	Numbness/Tingling	
Chronic pain	Fatigue	
Sleep disorders	Other	

		REPRODUCTIVE
Pregnant/Stage:	Nursing	
PMS/Infertility	Other	

		INFECTIOUS DISEASE
Name of Disease:		
Current Treatment		

		OTHER
Cancer/Tumors	Diabetes	
Eating Disorders	Depression	
Drug/Alcohol Addiction	Nicotine/Caffeine addiction	

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for the increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal adjustments. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ **DATE:** _____

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Birthday:	Social Security Number:
Occupation:	Employer:
Physician Name:	Physician Phone#:
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Massage Therapy Policies and Payment of Services

Please carefully read the following policies in order to facilitate a relaxing and therapeutic experience, a safe environment, and mutual understanding among Queen Anne Chiropractic Center, our massage therapists, and you.

- **Cancellation Policy:** Missed appointments are taken seriously at our office as this appointment time is especially dedicated and reserved for you. **We require that you cancel your appointment at least 24 hours in advance or pay the missed appointment fee in full.** If you need to notify us for any reason after office hours, please call and leave us a voice mail. If you require a call back, we will call you back at our earliest opportunity. Clients who constantly fail to show for their scheduled appointment time will not be scheduled for future appointments. Gift certificates may be forfeited for cancellations with less than 24 hours notice. Gift certificates will be forfeited for no shows. Your insurance company will NOT pay for your missed appointment.
- **Lateness Policy:** Please arrive early for your appointment. If you have not arrived within 15 minutes of your session start time, you have missed your appointment and you will need to pay our missed appointment fee in full.
- **Sickness Policy:** We recognize that both massage therapists and clients are vulnerable to infections and therefore ask clients to cancel appointments when they are feeling sick. As we also respect your time, we will do our best to provide as much notice as possible if your scheduled therapist becomes ill and will not be able to make it to your session. If you have any of the following contagious illnesses, the massage session will be rescheduled:
 - Diarrhea, Vomiting, Fever, Chicken Pox, Measles, Mumps, Meningitis, Hepatitis A, Conjunctivitis, Rubella, Head Lice, Impetigo, Influenza, Meningococcal Disease, Polio, Ringworm of the body, feet or scalp, Scabies, Thrush, Whooping Cough, and the Common Cold.
- **Insurance Policy:** If you have eligible insurance benefits that may cover your massage therapy session, you will need to provide the front desk personnel with this information prior to or at the time of your first qualified session. It is your responsibility to confirm your massage therapy benefits and eligibility. If for some reason your insurance fails to cover the session, you will be responsible to pay for the session in full. If you need a prescription, please provide the office with it *prior* to your appointment.
- **Communication:** Feedback about the effectiveness of the work is very important. This may include massage techniques that you have found to be beneficial, situations which may have been uncomfortable for you, and certain regions of the body that you would prefer to be avoided. Please feel free to share this information with us at anytime.
 - Requests for sexual activity will not be tolerated. This will be viewed as solicitation, and will be reported to the proper authorities under the guidelines of massage therapy policies and procedures. The client will not be rescheduled and will be dismissed from our office if this occurs.
- **Existing and New Medical Conditions:** It is your responsibility to keep the massage therapist informed of any medical conditions currently being monitored or treated. You will also need to provide written permission from your chiropractor, physician, physical therapist, etc, to verify that massage therapy may be continued. It is important that you inform the massage therapist of any changes in your health.
- **Scope of Practice:** To ensure appointment availability, you may wish to schedule a regular series of appointments. Massage stimulates the natural restorative processes of the body and mechanically reduces muscle tension. These methods may not be used to diagnose or treat any specific, preexisting condition without written permission from your physician. Massage therapists do not work within the parameters of licensed medical professionals. Therefore, massage therapists do not diagnose or prescribe for a particular body dysfunction nor are they allowed to provide treatment for a specific condition. The massage therapist is required to refer you for diagnosis and to follow the recommendations of your physician. Massage therapy is a maintenance system and the benefits are cumulative. It is best to receive a one-hour massage every week to reduce the physical stress that builds in the body. Massage may also be recommended for 2 or more times per week if you are treating for acute trauma and as directed by a physician. Appointments scheduled every other week, combined with gentle stretching and other self-help methods are also sufficient. Monthly appointments are beneficial for those who are effectively dealing with stress management. Occasional appointments provide temporary symptomatic relief, but the cumulative effects of therapeutic massage are lost if massage therapy is not achieved on a regular basis.
- **Payment:** It is your choice to receive massage. Payment of service is ultimately your responsibility. Payment will be collected at the time service unless otherwise prearranged. We accept cash, checks, Visa, MasterCard, and American Express. Checks are to be made payable to Queen Anne Chiropractic Center.

Signature: _____

Date: _____

Printed Name _____