Initial Intake Form

Please Print

Name_____ Date_____

Address _____ SS# Insurance Only_____

_____ TDL#_____

Phone Home _____ Birthdate _____

Office_____ Occupation _____

Cell _____ E-mail_____

In case of emergency notify – Name_____ Phone _____

Whom may I thank for this referral? _____

What is your major concern today? _____

Other areas of concern? _____

Have you ever had a massage before? Yes No

Are you currently under the care of a health professional for any reason?

Yes No Diagnosis?_____

Please list previous injuries, including broken bones, NOT requiring surgery:

_____

Previous surgeries with approximate dates: _____

_____

Please circle any illness or medical conditions which apply:

Diabetes	Headache	Painful Joints	Ruptured/Bulging Disc
Arthritis	Contact Lenses	Liver Disorders	Elevated Cholesterol
Seizures	Heart Condition	Scoliosis	High Blood Pressure
Cancer	Skin Disorders	Depression	Infectious Conditions
Stroke	Varicose Veins	Pins/Needles	Autoimmune Disorder
Phlebitis	Loss of Balance	Bruxing/Grinding	Previous MVA/Trauma

Other: _____

Medications: Vitamins_____ Herbs _____ Muscle Relaxers_____

Aspirin/Anti-inflammatories_____ Sleeping Aids _____

Anti-Anxiety/Depressants_____ Pain Reducers _____

Other _____

In which part(s) of your body do you feel stress most often? Check all that apply.

Head _____ Neck _____Back _____ Shoulders _____

Extremities_____Digestive _____ Other _____

Are there any areas that you would specifically like to have worked on?

_____

Any possibility that you are pregnant? Yes No

I have completed this form to the best of my knowledge. I will not hold the therapist responsible for injury due to undisclosed illness or condition.

Signature _____ Date _____

CONSENT FOR THERAPY

- The unclothed body will be properly draped at all times for your warmth, a sense of security and as a mark of massage professionalism.
- Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort and or health promotion. My therapist has discussed the potential benefits and possible side effects of this therapy. I have been given an opportunity to ask questions.
- Breast massage for female clients will not occur without prior written consent.
- I, as the client, agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is **not** a substitute for primary medical treatment.
- Written referral is requested from your primary care provider if:
    - You are currently receiving care or
    - You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- I understand that if I am uncomfortable for any reason, I can request for the massage to be terminated and my massage therapist will respect and honor this request.
- I understand that this professional massage is therapeutic in nature and is performed by a trained, state-licensed therapist. During the initial interview, the therapist informed me of her credentials.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.
- Our time together is important and I agree to cancel 24 hours in advance. Unless there is an emergency, if I miss an appointment I agree to pay the full appointment fee.
- I understand the information exchanged during any massage session is educational in nature and intended to help me become more familiar and conscious of my own health status and is to be used at my sole discretion.
- I verify that I am not involved in any active or pending legal process related to my physical symptoms.
- I have read this form and hereby freely give my permission to be massaged.

Date: _____Signature:_____

IMPORTANT NOTICE

Spinal Care Chiropractic Center
Acupuncture, Massage, Pilates/Rehab
Cancellation/Rescheduling Policy

Spinal Care Chiropractic Center has a strict **24 Hour Cancellation/Rescheduling Policy** for **ALL** Acupuncture, Massage and Pilates/Rehab appointments.

A Cancellation/Rescheduling Fee will be incurred for not cancelling or rescheduling accordingly.

For **Acupuncture**, the fee will be **$ 65.00.**

For **Massage**, the fee will be **$75.00 for 1 hour** massages,
$55.00 for 45 minute massages,
$45.00 for 30 minute massages.

For **Pilates/Rehab,** the fee will be **$ 50.00.**

We understand some cancellations and reschedules will be **unforeseeable** and will do what we can to work with those instances. In those instances we ask that you call before your appointed time to cancel.

Please sign below to acknowledge receipt of this policy:

Patient/Client Signature: _____

Date: _____

If you have any questions, please don't hesitate to contact our Office Manager, Janelle Kimball. She can be reached at 281-292-6644 ext. 13.

Thank you!
Spinal Care Chiropractic Center Doctors & Staff