Chiropractic**Care**
of Tri-Cities

MASSAGE PATIENT INFORMATION

Name: ______________________________ **Date:** __________
Last First Middle

Address: ______________________________
City State Zip Code

Home Phone: __________ **Work Phone:** __________ **Cell Phone:** __________

Employer: ______________________ **Referred By:** ______________________

Social Security No.: ______________ **Birthdate:** __________ **Age:** ______ **Sex:** ❑ **Male** ❑ **Female**

Primary Care Physician: ______________________ **Spouse Name:** ______________________

Emergency Contact Name and Phone No.: ______________________________

Email:______________________

RECORDS AUTHORIZATION

❑ **Yes**
❑ **No** **I authorize phone messages may be left on my answering machine.**

I authorize all medical records to be released and or discussed with: ______________________
(Spouse/family member, etc...)

CONSENT FOR PAYMENT AND TREATMENT

I authorize my insurance company to make payment directly to the providers of Chiropractic Care of Tri-Cities in an amount equal to their contracted fee for treatment. I authorize the office of Chiropractic Care of Tri-Cities to release any information pertinent to any insurance company, adjuster attorney to facilitate collection by signing this agreement. I authorize the providers of Chiropractic Care of Tri-Cities to examine any and all healthcare records pertaining to any injury or condition I am seen for. In the case of an auto accident or third-party accident, I assign the providers of Chiropractic Care of Tri-Cities any and all insurance benefits, settlement or judgement proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with the providers of Chiropractic Care of Tri-Cities are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees. I am aware that I am solely responsible for paying the providers of Chiropractic Care of Tri-Cities for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services.
I hereby consent to the performance of massage therapy. I understand that no guarantee or assurance has been given about this treatment.

Patient's Signature:	**Date:**
If Minor, Name of Parent / Guardian: **Parent / Guardian Signature:** **Consent to treat Minor in Parent's absence: YES / NO (please circle one)**	**Date:**

HIPAA COMPLIANCE NOTICE

I have received a copy of the HIPAA Compliance Notice. Initial:

Provider Signature :	**Date:**

Massage Intake Form

Personal Information

Name ____ Phone (day) ____________________ (evening) ____________________

Address ____________________________________ City/State/Zip ________________________________ DOB ___________

Occupation ____ Employer ____

Email ____ Primary Physician _______________________________________

Emergency Contact ___________________________________ Relationship __________________ Phone __________________

How did you hear about us? ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: ______________________

____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ______________________________

Any high risk factors? ______________________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ______________________________

What makes it better? ______________________________

____

What makes it worse? ______________________________

____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _________________________________

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐Sprains or Strains

Explain any conditions you have marked above:

____

____

____

____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain ________________________________

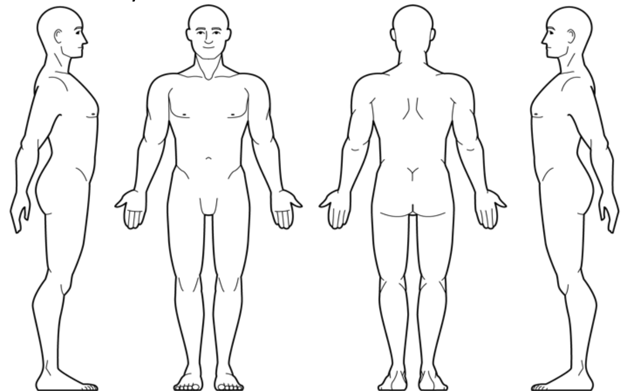
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ________________________________

What are your goals for this treatment session?

____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature __________________________ *Date* __________

Therapist Signature ________________________ *Date* __________

604 Williams Blvd. Suite A
Richland, WA. 99354

Telephone: (509) 946-0631
Fax: (509) 946-0632

CANCELLATION AND RESCHEDULING

In consideration of our clients and massage therapists we require at least 24 hours notice to reschedule or cancel your massage appointment prior to the appointment time. If change of appointment time is not appropriately given, the client may be charged a $40 fee. No-shows will be treated as cancellations without notice, and the $40 fee will be charged. Two no-shows may disqualify the client from future bookings.

If you arrive late to your scheduled appointment, the remaining time of the appointment will be utilized to provide the best massage/bodywork possible and you will be charged for the full hour that was scheduled. Thank you for your understanding.

Patient Signature (Parent if Minor): ______________________________________