First Name _____

Last Name _____

Email Address _____

Home Phone # _____

Street Address _____

State _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

Date of initial visit _____

Date of birth _____

Referred by _____

Mobile Phone # _____

Work Phone # _____

City _____

Zip Code _____

Physician's name _____

Physician's phone # _____

How would you rate your general health?

◯ Excellent ◯ Good

◯ Fair ◯ Poor

Have you had a professional massage before?

◯ Yes *(Date of last treatment)* _____

◯ No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

HEAD NECK

- ◯ Headaches / migraines
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

RESPIRATORY

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

NERVOUS SYSTEM

- ◯ Sensory loss / change
- ◯ Numbness / tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynecological problems

CARDIOVASCULAR

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis / varicose veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric disorder
- ◯ Other conditions _____

_____

_____

_____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____

arcadia health chiropractic

Massage Therapy Policies

Session Durations
The following time structures are provided below.
60 Minute: 10 minute disrobe and dress time, 50 minute body work
90 Minute: 10 minute disrobe and dress time, 80 minute body work

Financial Responsibility
As a patient of Arcadia Health Chiropractic, I take complete responsibility for any outstanding charges, late fees, or no-show fees.

Appointment Scheduling
All appointments will be scheduled through the receptionist and not by the massage therapist herself. This is to ensure that no patient will be double-booked. It is the patient's responsibility to arrive on time to the scheduled appointment.

Rescheduling Appointments
All appointments must be rescheduled at least 24 hours in advance. If an appointment is not rescheduled 24 hours in advance it will result in the full cost of your massage session.

Late Cancellations and No-Shows
Failure to cancel your appointment 24 hours in advance will result in the full cost of your massage session that must be paid before your next appointment. If no notice is given (no-show), your appointment will be deemed as a no-show resulting in the **full cost** charge of the missed service. The full cost charge must be paid before your next appointment. If you are under a package treatment plan, one session will be deducted from your package.

Late Arrivals
If you arrive late to your scheduled appointment, treatment time will be cut short and only the remaining time of your scheduled session will be given.

Termination of Care
If you decide to terminate your care when under a prepaid package treatment plan, you will receive a refund of the remaining credit for any massage therapy sessions that have not yet been received. All sessions will be prorated back to the original price:

60 Minute: $115
90 Minute: $160

The remaining balance will then be refunded. You must submit action of your termination in writing. All credit will be returned within 15 business days from your date of termination.

I, (print name)_____understand and agree to the Massage Therapy Policies.

_____Signature _____Date