Massage Intake Form

Please fill out ALL information as thoroughly and accurately as possible.

Name: ______________________________________ Date of Birth: _____________
Address: ____
City: ________________________________ State: ________ Zip: ________________
Phone: HM _________________ WK _________________ Cell _________________
Emergency Contact: ______________________________ Phone: ________________
Email: ____________________________ Occupation: __________________________
Whom may I thank for referring you? _____________________________________

Health and Medical Information

Please check any that apply to you today or in the past:

____ High Blood Pressure	____ Osteoporosis	____ Low Back Pain
____ Low Blood Pressure	____ Bursitis	____ Arthritis
____ Blood Clots	____ Broken Bones	____ Skin Infection/Rash
____ Varicose Veins	____ Muscle Sprains	____ Stroke
____ Pregnant	____ Muscle Strains	____ Diabetes
____ Contact Lens	____ Headaches	____ Contagious Cond.
____ Allergies	____ Nut Allergy	____ Other Cond.

Explain any above: ____
____

Y / N Are you currently taking Medication?__________________________
Y / N Do you bruise easily?
Y / N Do you suffer from Epilepsy or seizures?
Y / N Do you have cardiac or circulatory problems?
Y / N Do you experience muscle tightness / cramping?
Y / N Do you experience Sciatica, numbness, tingling or disc issues?
Y / N Do you experience dizziness, loss of balance or fainting spells?

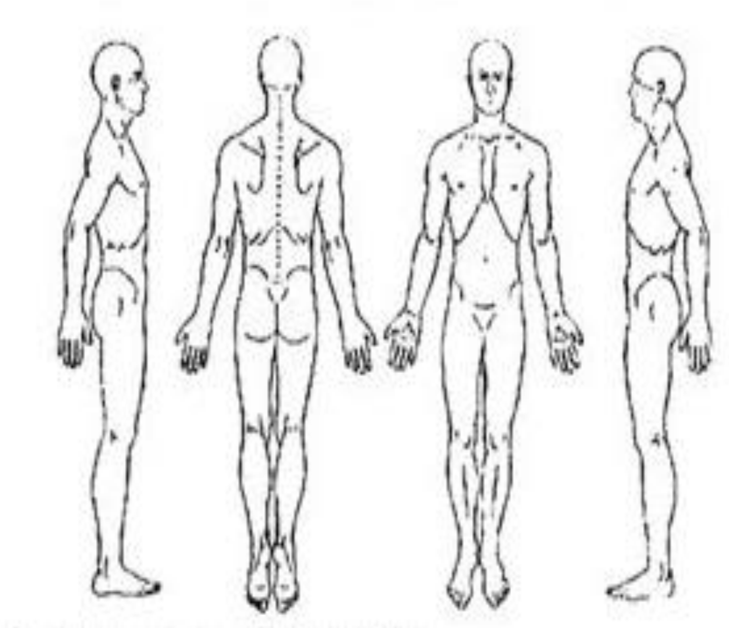
Please list any broken bones, fractures, accidents or surgeries within the last 5 years:____
____

Are you currently under the care of a physician, if **YES** why?
____

(**PLEASE** see other side)

Are you pregnant? ________________________
Have you had a professional massage/bodywork session before? _____________
If **YES**, when and what type? ____

Please indicate with an (X) any areas of the body that are causing you pain or discomfort:



I attest that the above is true and accurate to the best of my knowledge and will notify the therapist of any updates or changes. I understand that Massage Therapy services are a therapeutic health aid and **do not** take the place of a physician's care or services when indicated. I will consult with a physician before our massage session takes place; such therapy may be considered a contraindication for me as the client. If I am unable to make a scheduled appointment, I agree to cancel within 24 hours, unless I have an emergency. If I miss a scheduled appointment without giving 24 hours notice, I may be charged in full for the price of the missed session.

Signature: _____________________________________ Date: __________________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another who is waiting to be scheduled in that appointment time slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Canton Chiropractic and Massage holds the right if massage appointments are cancelled with less than 24 hours notification, the patient scheduled is subject to a **$40.00** cancellation fee.

Canton Chiropractic and Massage holds the right if patients do not show up for their appointment without a call to cancel a massage appointment will be considered a **NO SHOW** and subject to a **$40.00 fee.**

Canton Chiropractic and Massage holds the right if a patient shows up more than 5 minutes late to their massage appointment to charge the patient the full amount of the massage even though the patient will not receive the full time for the massage after being tardy. Massage is run on a tight schedule and time that goes over in one appointment, affects everyone else's appointment through the entire day. We ask you to be courteous to others and show up at your **SCHEDULED** appointment time.

The Cancellation and No Show fees are the sole responsibility of the patient and will be billed after the occurrence along with having to be paid in full before the patient's next appointment.

Our practice believes that a good relationship is based upon understanding and good communication. Questions about cancellation and no show fees can be answered at any time.

Please sign that you have read, understood and agreed to this Cancellation and No Show policy.

___________________________	__________________________________	____________
Patient Name (Please Print)	**Signature of Patient**	**Date**