Confidential Massage Health Intake

Patient Name:____ DOB:________________
Full Address:____
Phone:____________________________ Date of Injury:____________________________
Email Address:________________________________ Referred By:_______________________
Insurance Provider:________________________________ Mbr ID#:__________________
Insurance or Claim Adjustor Phone#:____
Coming for: Auto ☐ or Work ☐. Claim#:____
Occupation:_________________________________ Employer:______________________
Emergency contact/phone#:___________________________ _______________________

Health History: Please check/circle those which apply (past or present):

Musculoskeletal:
__ bone or joint disease
__ arthritis, inflammation
__ lower back/hip pain
__ disc herniation
__ midback/shoulder pain
__ neck pain, headaches
__TMJ
__ fibromyalgia, CFDS
__ other

Other:
__ cancer, tumors
__ any infectious disease
__ high/low blood pressure
__ lung problems
__ other

Skin:
__ rashes, warts, lesions
__ eczema
__ other

Digestion:
__ IBS, Chrohns
__ diabetes I or II
__other

Reproductive:
__ current pregnancy
__ breast surgeries
__ inguinal hernia
__ lymphatic problems, swelling
__ other

Nervous:
__ numbness, tingling, neuralgia
__ herpes, shingles
__ loss of function, weakness
__ other

Circulatory:
__ heart condition
__ varicose veins
__ blood clots, DVT
__ other

Recent Surgeries? When? ____

Please list any medications/supplements you are taking:

____

____

Have you ever received professional massage? Yes No
Do you have allergies (i.e. oils, scents…)? Yes No

**I understand that massage practitioners do not diagnose illness, disease, or any other 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 it is recommended that I see a primary health care provider for that service. It is my choice to receive massage therapy, and I agree to communicate clearly with my practitioner if any concerns arise with my health or sense of well-being. I have stated all medical conditions I am aware of and take responsibility to keep my practitioner informed of any changes in my health status.
**I authorize my insurance carrier and/or claim provider (if applicable) to send payment directly to Proctor Chiropractic. I understand that if my claim is denied for any reason, I am responsible for my related charges.

Signature:______________________________________ **Date:**_________________________

Proctor Chiropractic Center
3910 6TH Ave Tacoma, WA 98406
(253)-756-7500

Massage Policy/Cancellation Fee

Thank you for choosing Proctor Chiropractic as your massage provider. Massages are scheduled for one-hour. Your one-hour session consists of 50 minutes of massage and 10 minutes of time for consultation and dressing. If a client is late for a massage, the hour will be adjusted by the therapist to use only the time remaining originally blocked out for that client.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 business hours notice in order to reschedule your massage appointment.

You will be charged $50 for cancelling appointments with less than 24 business hours notice. This charge is NOT covered by insurance and will be your direct responsibility. You will be unable to schedule any further massages until this fee has been paid. If you have a series of massages scheduled, all subsequent massages will be cancelled until this charge has been paid.

We have the ability to send text or email reminders 24 hours before your appointment.
Check which reminder you would like to receive (please choose one):

- o **Text:** Cell Phone Number:____
  Cell Phone Provider (Sprint, Verizon, etc.):______________________
  (note: T-Mobile subscribers often do not receive reminders and email reminders are recommended)

- o **Email:** ____________________________________@_________________________

Please note that this service is a courtesy to our patients and we are not responsible for messages that have not been received.

I have read and understand the above cancellation policy.

____ ______________________

Signature Date