Atlantic Chiropractic & Rehabilitation

115 Kempsville Rd, Suite One
Chesapeake, VA 23320
757-547-HEAL (4325)

Massage Therapy Intake Form

Name _____ Date _____

Address_____Phone (C) _____(H)_____

_____ Date of Birth_____

Sex: M___ F___ Email address _____

Form of Payment (Self pay, Insurance, Gift Certificate, Coupon, Etc) _____

Women only, are you pregnant? _____

Who referred you to this office? _____

Name of primary care physician_____

Have you received massage therapy before? _____ When? _____

Are you having discomfort today? _____ Where? _____

Have you been seen by another professional for this problem? _____

Have you done any self-care for this problem? _____ If so, What type? (Ice, Heat, stretching, etc.)

_____

Is this problem the result of an accident? _____ If so, briefly describe the accident (car accident, fall, etc.) _____

Place an "x" next to each of the following that pertain to you

___Digestive System	___Vision	___Lupus	___Arthritis
___Nervous System	___Rashes	___Diabetes	___Leg Pain
___Circulatory System	___Emotional Abuse	___TMJ	___Foot Pain
___Emotional Abuse	___Stress	___Cancer	___Back Pain
___Nervousness	___Depression	___ High Blood Pressure	___Hip Pain
___Repetitive Motion Injuries		___Shoulder/Arm Pain	___Neck Pain

Do you Exercise?_____ How Often?_____ What type?_____

How Many glasses of water do you drink a day? ___6-8___4-6___1-3___None

Are you on any medication? Please List_____

Are you allergic to any ingredient found in lotions and/or oils? _____

Are you sensitive to any type of Scent? _____

Emergence Contact_____Phone_____

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Attention Massage Patients

In order to provide our patients with the best experience, please be advised that our office requires at least a 24 hour notice for massage cancellations. If your appointment is missed, YOU (not your insurance) will be held responsible for the full (U&C) price of the scheduled massage. _____ initials

If you would like to tip your massage therapist today, Please do not include it in your payment. Cash and separate checks (payable to the massage therapist) are acceptable forms of gratuity payment. _____ initials

I have read the statement above and agree to these terms.

Signature_____Date_____

***Please provide a copy of your credit card along with completed authorization below:*

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Each time a patient sees a doctor, is admitted to a hospital, goes to a pharmacist or is seen in a massage therapy office (for instance) a record is made of their confidential health information. Congress recognized the need for a national patient record privacy standard in 1996 and approved the Health Insurance Portability and Accountability Act (HIPPA).

The HIPPA Act covers all medical records and other individually identifiable health information used or disclosed by a patient in any form whether electronically, on paper, or orally. This means that your health information cannot be disclosed, shared or transferred to any other office or individual without your expressed consent.

This office works under strict HIPPA Act regulations. Signing this document indicated that you have been informed of your rights as a client at this establishment.

_____ _____

Signature Date