Family Chiropractic

Massage Questionnaire

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First Name:_____ MI: ____ Last Name:_____
DOB: ____/____/_____ Age: _____ Gender: ❑ Male ❑ Female SSN: _____
Name Suffix: ❑ Jr. ❑ Sr. *(If applicable)*

Address 1:_____ Address 2: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____
Preferred Communication: ❑ Phone ❑ Mail/Letter ❑ Email ❑ Patient Portal ❑ Fax ❑ Decline
Confidential Communications: ❑ Home ❑ Work ❑ Mobile ❑ Email ❑ Patient Portal ❑ Mail ❑ Decline
Personal Email: _____
How would you like to receive appointment reminders?
❑Text Message ❑Email ❑I choose to decline appointment reminders.

Have you ever experienced a professional massage or bodywork session? Yes☐ No ☐
If yes, how recently? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes ☐ No☐ Do you frequently suffer from stress?
Yes ☐ No☐ Do you have diabetes?
Yes ☐ No☐ Do you experience frequent headaches??
Yes ☐ No☐ Are you pregnant?
Yes ☐ No☐ Do you suffer from arthritis?
Yes ☐ No☐ Are you wearing contact lenses?
Yes ☐ No☐ Are you wearing dentures?
Yes ☐ No☐ Do you have high blood pressure?
If "yes" to previous question, are you taking medication for this? Yes ☐ No☐
Yes ☐ No☐ Do you suffer from epilepsy or seizures?
Yes ☐ No☐ Do you suffer from joint swelling?
Yes ☐ No☐ Do you have varicose veins?
Yes ☐ No☐ Do you have any contagious disease?
Yes ☐ No☐ Do you have osteoporosis?
Yes ☐ No☐ Do you have allergies?

Yes ☐ No☐ Do you bruise easily?
Yes ☐ No☐ Have you had any broken bones in the past two years?
Yes ☐ No☐ Have you been in an accident or suffered any injuries in the last two years?
Yes ☐ No☐ Do you have cardiac or circulatory problems?
Yes ☐ No☐ Do you suffer from back pain?
Yes ☐ No☐ Do you have numbness or stabbing pain anywhere?
Yes ☐ No☐ Are you very sensitive to touch or pressure in any area?
Yes ☐ No☐ Do you have any other medical conditions or are you taking any medications I should know about?
Yes ☐ No☐ Have you ever had surgery? If yes, explain below

Comments:
_____
_____

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

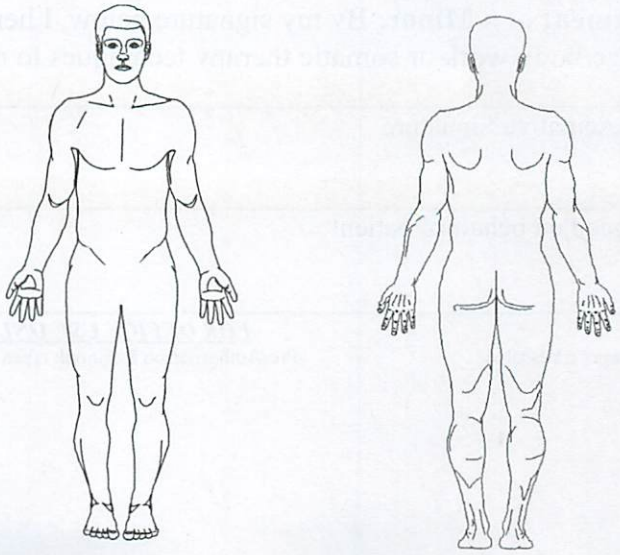
Key:
Numbness - - - - - - -

Pins and Needles oooooooo

Burning xxxxxxxx

Stabbing/Sharp ////////////////

Aching/Dull ********
Popping/Clicking P P P



Massage Referrals/Prescription & Pre-Authorization

Massage Therapy is a common insurance benefit. This benefit must be referred by either your primary care or chiropractic provider. Having a referral does not guarantee coverage/payment from your insurance payer. Pre-authorization of Massage Therapy is required by specific insurance providers and plans. This is in addition to the prescription/referral. Pre-authorization approval of treatment does not guarantee payment from the insurance provider.

Initial: _____

No Show/ Late Cancellation Policy

As a courtesy, you are able to opt in for a text or email to confirm your service appointments. This will send you a reminder one business day prior to your appointment date. If you are unable to attend your massage appointment, we require that you verbally cancel your appointment with the receptionist the business day prior to your appointment time. In the event the patient does not attend or cancel the business day prior to their schedule appointment time, a fee of $60.00 with be billed to the patient. This fee is NOT billed to your insurance payer; it is entirely the patient's responsibility. A credit or debit card on file is required to make any massage reservations. This card is charged when our cancellation policy is violated.

Initial: _____

Informed Consent

I understand that the massage/body work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or body work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/body work practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that notion said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____

Signature of the Patient Date

Consent to Treatment of a Minor: By my signature below, I hereby authorize the massage practitioner to administer massage/body work or somatic therapy techniques to my child or dependent as they deem necessary.

_____

Patient/Legal Representative Signature Date

_____

Printed Name if signed on behalf of patient Relationship

FOR OFFICE USE ONLY

Massage Insurance Coverage? □Yes □No Pre-Authorization Required: □Yes □No Massage RX up-to-date? □Yes □No