Family Chiropractic
204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

Massage Questionnaire

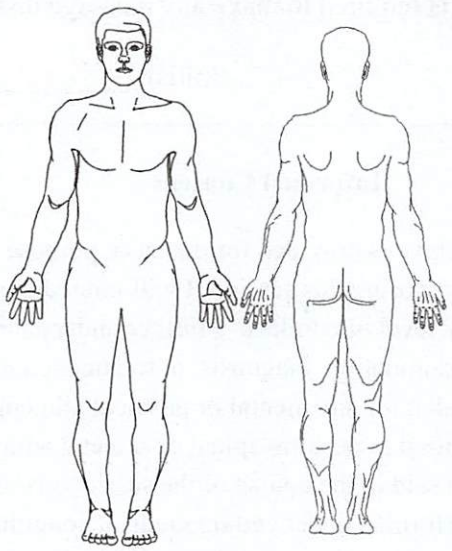
Jessica Mason LMT

First Name:_____ MI: ____ Last Name:_____ Suffix: ❑ Jr. ❑ Sr.
DOB: ____/____/_____ Age: _____ Gender: ❑ Male ❑ Female SSN: _____
Address 1:_____ City/State/Zip code: _____
Home Phone: _____ Mobile Phone: _____
Preferred Communication: ❑ Phone ❑ Mail/Letter ❑ Email ❑ Fax ❑ Decline
Confidential Communications: ❑ Home ❑ Work ❑ Mobile ❑ Email ❑ Mail ❑ Decline
Personal Email: _____
How would you like to receive appointment reminders?
❑Text Message ❑Email ❑I choose to decline appointment reminders.
Occupation:_____

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

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



How Much pressure do you prefer:
❑ Light ❑Medium ❑Firm

Skin Conditions:
❑ Rash ❑ Acne ❑ Wounds
❑ Other:_____

Are you taking any medications or supplements? ❑ Yes ❑ No If yes, please list:

Name	Dosage	Name	Dosage

Areas of swelling	Yes	No	Diabetes	Yes	No	Osteoporosis	Yes	No
Autoimmune Disorder	Yes	No	Fibromyalgia	Yes	No	Phlebitis	Yes	No
Back/Neck Problems	Yes	No	Headaches	Yes	No	Sciatica	Yes	No
Bleeding Disorders	Yes	No	Heart Condition	Yes	No	Seizures	Yes	No
Blood Clots	Yes	No	Hypertension	Yes	No	Stroke	Yes	No
Bruise easily	Yes	No	Kidney disease	Yes	No	Tendinitis	Yes	No
Bursitis	Yes	No	Multiple Sclerosis	Yes	No	TMJ Disorder	Yes	No
Cancer	Yes	No	Neurological Condition	Yes	No	Varicose Veins	Yes	No
Contagious Condition	Yes	No	Neuropathy	Yes	No	Vertigo/Dizziness	Yes	No
Decreased sensation	Yes	No	Osteoarthritis	Yes	No			

Any Allergies? (oils, lotions, nuts, fruits, skin etc.) ❑Yes ❑ No If yes, please list:_____

Are you pregnant? ❑ Yes ❑No If yes, how many months:_____ Due Date:_____

Are you currently under medical supervision or receiving medical interventions? ❑ Yes ❑ No

If yes, please describe:_____

Massage Referrals/Prescription & Pre-Authorization

Massage Therapy is a common insurance benefit. This benefit must be referred to you 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 can 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 scheduled appointment time, a fee of $70.00 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

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