Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

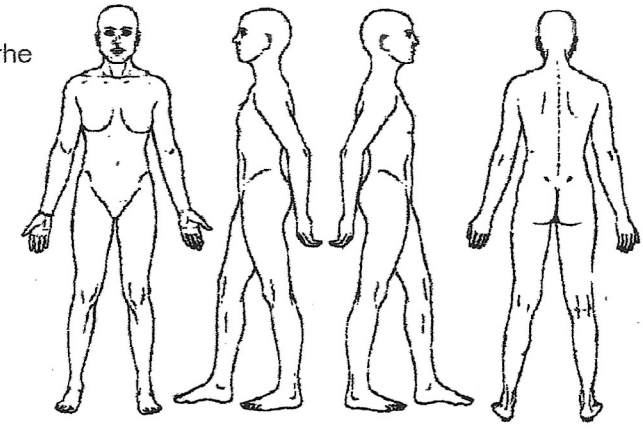
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy If yes, how many months?
( ) atherosclerosis	

Please explain any condition that you have marked above _____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Olivieri Chiropractic inc.

Patient Name: _____ **Date:** _____

Patient Guide to Scheduling Appointments

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your health and well-being and recovery of your optimal health is something everyone in our office takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your healing process. Therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Please write down the dates and times of your future appointments or put them into your smart phone. We also provide a calendar with your appointment dates circled. It is vitally important that you complete all of the scheduled appointments before the date of your re-examination. Changing your re-examination date is against office policy and will delay in your healing and recovery.

Listed below are the policies regarding all appointments:

1. **No-Show:** This occurs when a patient is scheduled for an appointment and does not call or text to cancel or reschedule and does not show up for their appointment. This will result in an out of pocket no show fee of: **$60**, **$109** or **$159** for Massage Therapy and **$25** for a Chiropractic. **(Initial)** _____

2. **Without 24-Hour Notice**: This occurs when a patient is scheduled for an appointment and a call or text is made to cancel but does not give the office more than 24-hours notice in advance. The cancellation fee is **$60**, **$109** or **$159** for Massage Therapy. Chiropractic patients can re-schedule their appointment within one week without the assessed fee. **(Initial)** _____

3. **With 24-Hour Notice**: There is no fee assessed for Chiropractic and Massage Therapy appointments cancelled with more than 24-hours notice. We understand that things can happen, however, we would ask that patients do everything in their power to make up cancelled appointments in order to get the best results on their current treatment plan. All patients are encouraged to re-schedule their cancelled appointments within one week. **(Initial)** _____

In instances of repeated non-compliance with scheduled visits, we also reserve the right to discontinue care. This type of behavior is disruptive, time consuming, and takes valued treatment time away from other patients, the doctors, therapists, and receptionist.

A confirmation call or text is made the day before each patient's appointment. This is a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call or text does *not* validate a missed appointment, and the appropriate fee will be assessed.

By signing and initialing above, I have read and understand this guide: _____

Signature