Seattle Life Chiropractic
Massage Health History Intake Form

Client's Personal Information

Name:	DOB:
Address:	City/State/Zip:
Cell Phone:	Home Phone:
Social Security:	
Occupation/Employer:	Work Phone:
Emergency Contact:	Emergency Contact Phone:
Primary Care Provider:	Primary Care Provider Phone:
Email:	Referred by:

Client's Previous History

(Please fill in all that apply)

Surgeries: ____

Injuries/Accidents (Still affecting you) ____

Major Illnesses or other Hospitalizations ____

Client's Health History

(Please mark any that you have now or have had and provide any necessary clarifications)

- ☐ High or Low Blood Pressure ____
- ☐ Heart Condition ____
- ☐ Blood Clots ____
- ☐ Varicose Veins ____
- ☐ Allergies ____
- ☐ Sleep Disorders ____
- ☐ Prolonged episodes of depression ____
- ☐ Diabetes (If yes, how is it controlled?) ____
- ☐ Chronic Pain ____
- ☐ Arthritis ____
- ☐ Cancer/Tumors ____
- ☐ Any other medical condition that I should be aware of:

____

(Please Mark those that apply for **TODAY**)

- ○ Contact Lenses/Hard or Soft ________________
- ○ Dentures ________________________________
- ○ Hearing Aids ____________________________

Please List current medications (including aspirin, ibuprofen, herbal remedies, etc.) ________________________

Massage History

Have you ever received a professional massage? ____If yes, frequency? ____

What results do you want from these sessions?____

List any forms of stress reduction and/or exercise and frequency? ____

I understand that my massage therapist must be aware of any existing physical conditions that I have, I have listed all known medical and physical conditions and limitations and will inform Seattle Life Chiropractic in writing of any change in my physical health. I understand that my massage therapist neither diagnosis illnesses, diseases, or any other medical, physical, or emotional disorder nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have.

I also understand that Seattle Life Chiropractic reserves the right to stop the massage at any time if deemed necessary by my massage therapist and will also be responsible for paying for this session.

Signature: ____ Date: ________________________

<u>Seattle Life Chiropractic</u>
Massage Reservation Credit Card Authorization

If you cancel or change your appointment without 24-hours notice, or you do not show up for your appointment the credit card holding the reservation will be charged the full $60 of the appointment, and any missed appointment thereafter.

As a courtesy, we will attempt to fill your session if you change your appointment without 24-hours notice. If we are able to fill the session, we will not charge your card the $60 appointment fee.

Visa MasterCard Expiration Date _____________

Card Number ________________________ Name on card ______________________________

Zip Code ________________________

I authorize Seattle Life Chiropractic to run my credit card for the $60 massage fee if I change my massage appointment without giving 24-hours notice , or I do not show up for my appointment.

_________________________ ____________________________ ____________________________

Print Name Sign Name Date

Medical release

It is my choice to receive massage therapy. I realize the treatment is being given to me for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation and energy flow.

I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I understand massage practitioners do not diagnose illness, disease or any other form of physical or mental disorder. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

I acknowledge massage is not a substitute for medical examination or diagnoses and it is recommended I see a primary health care provider for that service.

I have stated all medical conditions I am aware of and will update the massage practitioner of any changes in my health status.

BENEFITS RELEASE: I authorize payment of medical benefits to Jeffrey M. Suver, D.C. for services rendered. I authorize release of my medical information or other **NECESSARY** information to process a claim for payment.

Signature:______________________________ **Date:**____________________