ABOUT THE PATIENT

Health and Healing Family Chiropractic

Name _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

Email _____ Type of Work _____

Emergency Contact _____Phone # _____

Have you had a massage before? ❑ No ❑ Yes

HEALTH INFORMATION

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

❑ 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 Do you have high blood pressure?
❑ 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 a contagious disease?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Have you been in a collision or suffered any injuries in the past two years?
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you have tension or soreness in a specific area? Please specify: _____
❑ Yes ❑ No Do you suffer from neck pain or back pain?
❑ Yes ❑ No Do you have numbness, tingling or sharp pains anywhere? Please specify:_____
❑ Yes ❑ No Are you very sensitive to touch or pressure in any area? Please specify:_____
❑ Yes ❑ No Have you ever had surgery? _____
❑ Yes ❑ No Do you have any other medical conditions or are you taking any medications I should know about?

Is there anything else you would like the therapist to know:_____

_____

Preferred Pressure:

❑ Light

❑ Moderate

❑ Deep

- I understand that the massage/bodywork I receive is provided for relaxation and relief of muscular tension.
- I will immediately inform the practitioner if I experience any pain or discomfort, so that the pressure and/or strokes may be adjusted.
- I understand that the massage/bodywork should not be construed as a substitute for medical diagnosis or treatment.
- I affirm that I have stated all my known medical conditions.
- 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 this session.
- I authorize the doctor or her staff to render care as deemed appropriate for me and/or my child.
- Person responsible for this account if other than the patient? _____

Patient / Parent Signature Date

Health & Healing Family Chiropractic

MASSAGE THERAPY GIFT CERTIFICATE POLICY

Health & Healing Family Chiropractic Inc, policy is that you must present your massage gift certificate prior to receiving service. If you do not have your gift certificate with you at the time of your appointment, you will be required to provide alternative payment for that massage. You will be able to utilize your gift certificate at another appointment time.

MASSAGE SCHEDULING AND CANCELATION POLICY

If you are unable to make it to your massage appointment, we require you to cancel at least 24 hours prior to your appointment. If 24 hours is not given, we will try to fill your massage appointment, if we are not able to fill your appointment time, your credit card will be charged for the full fee of the original massage price or if you are a massage club member a massage will be forfeited.

Massage fees that will be charged are as follows: 90 minute $145.97 patient, $156.78 non-patient, 60 minute $108.13 patient, $129.75 non-patient and 30 minute $70.28.

We require a credit card number on file prior to scheduling a massage appointment.

☐ Health & Healing Family Chiropractic will save your credit card number on an encrypted site.

Gratuity is always welcome but never required. Gratuity must be paid directly to your therapist in cash, check or Venmo.

Print Name_____
Signature_____

Date _____
Relationship if Patient is a Minor_____