



Massage Therapy Client Intake

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Home Phone: _____

Address: _____
Street Address City State Zip

Cell/Work Phone: _____ Employer/ Occupation: _____

Spouse's Name/ Phone: _____

Email Address: _____ How did you hear about us? _____

* For the use of Scott Chiropractic only

Primary Care Doctor: _____ Hobbies: _____

Emergency Contact Name/Phone: _____

General Consent: I understand that I am receiving a therapeutic massage intended to increase my quality of life. I agree to all treatments within the treatment parameters of the certified massage therapist. I will not hold the therapist or J. S. Chiropractic* liable for any injuries, accidents, communication differences, conflicts, or physical ailments that may occur during or after treatments. I understand that the massage therapist does not diagnose and I am responsible for seeking care with any other health professionals for any concerns regarding a condition/ailment or diagnosis. I agree to be responsible for all charges for services rendered. I also understand and have read the HIPPA agreement that I was given to review.

Financial Awareness and Consent: I understand I am financially responsible, whether or not my insurance company pays, for all charges incurred by me. I hereby assign my massage therapy benefits to J.S. Chiropractic*. I understand that all plans are different and I may have one or more of the following that I am responsible for: referral from PCP/ deductible/ co-pays/ percentage owed for each date of service/ or no massage therapy benefits. I understand that if I choose to bill any therapies to my insurance company all services will be itemized and the charges will exceed our discounted cash rate. I understand that any accounts that are 90 days overdue are subject to collections proceeding, regardless of case type. I also authorize Scott Chiropractic on Lake Loveland* (J.S. Chiropractic) to release any protected health information required to secure payment.

*Payment for services is required at the time of service. Any balances left unpaid are subject to a \$15.00 billing fee and will incur an additional \$15.00 billing fee each time a balance is re-billed.

Cancellation Policy: I understand that I will be responsible for an office visit of \$60.00 for an hour massage (subject to change) for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment. The massage schedule is very limited; therefore we strictly enforce this policy. Payment will be required within 14 days of missed appointment. Please also be aware that any patients arriving late for their scheduled appointment may be required to shorten their treatment time, wait until the next available opening, or reschedule their appointment and thus be subject to the above stated cancellation policy.

Patient's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

* If patient is a minor

*J.S. Chiropractic includes: Dr. Julie Scott, D.C., Melanie Waite, LMT, Stacey Glazier, LMT and Katrina Benavides, LMT

What is your reason for getting massage? _____

Have you ever had a massage before? **Yes / No**

If yes, what type of pressure do you prefer? Circle one: **Light (relaxing) / Medium / Deep Pressure**

If yes, do you prefer talking during your massage? **Yes / No**

Were you referred by a friend or other health care professional? **Yes / No**

If yes, by whom? _____

List all or any medications that you are currently taking:

List any or all herbal or other supplements you are currently taking:

List any injuries in the past 5 years: _____

List any surgeries / broken bones in the past 5 years:

WOMEN: Are you currently pregnant? **Yes / No**

If yes, how many weeks: _____

PLEASE CHECK ANY FO THE FOLLOWING THAT PERTAIN TO YOUR BODY AND HEALTH:

GENERAL:

- Sinus problems / allergies
- Numbness / Tingling
- Weakness
- Arthritis
- Seizures
- Fainting
- Dizziness
- Memory Loss
- Varicose Veins
- Diabetes
- Shortness of breath
- Heart Problems
- Blood Clots
- Lupus
- Multiple Sclerosis
- Skin Conditions
- Pain with Coughing / Sneezing
- Nausea
- Low Back Pain / Neck Pain
- Cancer
- Headaches
- High / Low Blood Pressure

HIPS / LEGS / FEET:

- Leg / Foot Cramps
- Swollen Ankles
- Tingling / Burning
- Shooting Pains
- Ticklish Feet

ARMS / HANDS:

- Weakness
- Clumsiness
- Shooting Pains

NECK / SHOULDERS

- Stiffness
- Tightness
- Burning
- Decreased Range of Motion
- Shooting Pains
- Popping / Clicking
- Ringing in Ears

**NOTIFY THE THERAPIST ON ANY OF YOUR VISITS IF YOU CURRENTLY HAVE A FEVER, ILLNESS,
OR CURRENT INJURY**