Elmenhurst Chiropractic Clinic

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Massage Therapy Initial Intake Form

File#_____

Name:_____ **Date:**_____
First Last MI

Mailing Address:_____**City**_____**State**_____**Zip**_____

Ph#:(hm)_____(wk)_____(cell)_____**SS#**_____**DOB:**_____**Sex** M F

Marital Status: M S W D Number of Children:___**Occupation:**_____ **Employer:**_____

Name of Spouse/Partner_____**Emergency Contact:**_____**Ph#**_____

Who may we thank for referring you to us?_____**Referring doctor:**_____

Ph#:_____**May we contact them if pertinent: Y/N Currently Pregnant Y N Possible**

Will we be billing insurance for you? Yes □ No □ ID#_____**Group#**_____ **Ins. Co.**_____

Subscriber_____ **Subscriber's DOB**_____ **Subscriber's SS# (for billing purposes)**_____

In which part(s) of your body do you feel stress most often?

- ❑ head
- ❑ neck
- ❑ shoulders
- ❑ back
- ❑ extremities
- ❑ other:

Recent injuries *not* requiring surgery (including broken bones):_____

_____

Recent surgeries with approximate dates (within the last year):_____

_____

Please review this list and circle any illnesses and/or conditions that apply:

- ❑ diabetes
- ❑ arthritis
- ❑ seizures
- ❑ cancer
- ❑ stroke
- ❑ scoliosis
- ❑ loss of balance
- ❑ other:
- ❑ contact lenses
- ❑ heart condition
- ❑ skin disorder
- ❑ varicose veins/phlebitis
- ❑ painful joints
- ❑ previous MVA/trauma
- ❑ fatigue/depression
- ❑ ruptured/bulging discs
- ❑ pins/needles/numbness/tingling
- ❑ high blood pressure
- ❑ infectious conditions
- ❑ auto-immune disorder
- ❑ headache
- ❑ bruxing/grinding teeth

Medications:

- ❑ muscle relaxants
- ❑ over-the-counter pain reducers
- ❑ other:
- ❑ prescription pain reducers
- ❑ sleeping pills
- ❑ anti-inflammatory
- ❑ anti-anxiety/depressants

Please list any vitamins, minerals, and/or herbs that you regularly take:_____

_____

Any Allergies your therapist should be aware of? _____

_____

What are your goals for massage therapy?_____

_____

Are there any areas that you would prefer *not* to be massaged?

- ❑ face
- ❑ legs
- ❑ arms
- ❑ abdomen
- ❑ scalp
- ❑ feet
- ❑ neck
- ❑ buttocks
- ❑ hands
- ❑ back
- ❑ chest

I agree to provide complete and accurate health information and give notice of health changes at successive appointments as appropriate.

- ❑ Massage Therapy Policy

Signature:_____**Date:**_____

Elmenhurst Chiropractic Clinic
MASSAGE INFORMATION AND POLICIES

If you have had massage before, you know the benefits it can bring. If you are new to massage, you may have some questions. Please feel free to ask us at any time. Below we have provided the answers to some commonly asked questions and concerns.

1. You will be asked to disrobe to your level of comfort. If you have any reservations or concerns regarding disrobing, please let your massage therapist know at the beginning of your appointment.

2. For a one-hour massage therapy session, the actual hands-on massage time will be approximately 50 minutes. This allows time for you to disrobe and for the therapist to assess your current condition and understand your goals for the upcoming session.

3. Fees are **$96.00 for a one-hour session** and **$48.00 for a half-hour** at time of service.

4. We love children; however, so that you may receive the full benefit of your massage treatment, we discourage them from being present.

5. **Turn off mobile phones**, pagers, etc. in the treatment rooms.

6. Massage is powerful and therapeutic. Drinking plenty of water before and after your massage is very important. Muscles and joints need to be hydrated to prevent cramping and the accumulation of toxins. Water is key to flushing these toxins from your body.

7. If your immune system is fighting a cold or the flu, or you are experiencing any health problems that you feel may affect your massage, please inform your therapist **before** your appointment.

8. You may be instructed to ice specific areas after your treatment since your muscles have worked in a new way. You may experience some stiffness or tenderness the next day. This is common, but icing will reduce this a great deal. If tenderness lasts more than a day, let your therapist know at your next appointment or feel free to give us a call. If your body is unusually sensitive to more than light massage, please discuss this with your therapist. This will enable us to give you the best treatment possible for your body.

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondence, billing statements and any other information to my attorneys, healthcare providers and insurance case managers.

- _____(Pt initial) **GENERAL INSURANCE PAYMENT POLICY:** Your portion of the services (full amount, co-pay, deductible, etc.) is due on the day of service.

- _____(Pt initial) If your insurance covers massage treatment, we will provide for your insurance company all necessary documentation, but we cannot accept responsibility for non-payment, late payment, or for negotiating a disputed claim. Your insurance policy is a contract between you and your carrier. **Even though we may have been given information by your insurance company regarding the benefits of your plan, this is not a guarantee of payment.** All balances over 90 days will be converted to cash claims.

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I am also fully aware that this a professional massage from a professional Massage Practitioner and no crude or sexual behaviors, comments, or insinuations will be tolerated. If such behavior should arise the Practitioner will terminate the session and the client will be responsible for the full cost of the massage and asked not to return.

Due to the nature of scheduling, we ask that you arrive in a timely manner. In addition, we request **24 hours notice** to change or cancel appointments. If you do not provide **24 hours notice**, there will be a **$40 no-show/late cancellation fee**. It will be your responsibility to pay this fee – it cannot be charged to your insurance company. This $40 no-show fee must be paid before any additional care will be provided and must be paid at least 3 days prior to any appointments already scheduled to avoid automatic cancellation. Thank you for your cooperation and understanding in this matter.

I have reviewed the information and policies listed above. (Patient may request a copy of these policies for their records.)

Signature: _____ Date: _____

Name (printed): _____