Client Health Record - Massage

CLIENT INFORMATION

NAME:		DATE:
PREFERRED NAME / NICKNAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:	AGE:	GENDER: M F

□ DIVORCED □ MARRIED □ SEPARATED □ SINGLE □ WIDOWED

OCCUPATION:

HOW DID YOU HEAR ABOUT OUR OFFICE?

MASSAGE INFORMATION

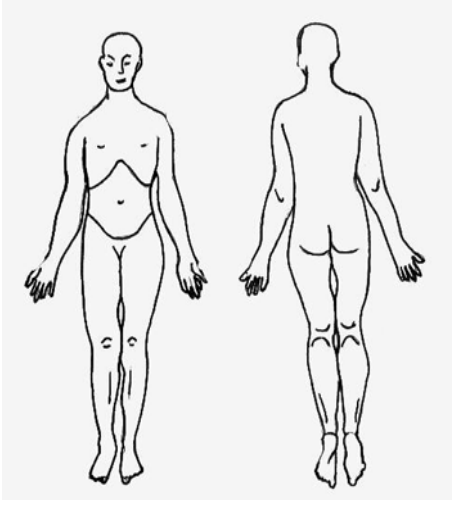
HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? □ YES □ NO

WHAT TYPE OF PRESSURE DO YOU PREFER?

□ LIGHT □ MEDIUM □ FIRM

ARE THERE ANY AREAS THAT YOU WOULD ***NOT*** LIKE WORKED ON?

CIRCLE ANY AREAS YOU WOULD LIKE TO CONCENTRATE ON:



REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

WHEN DID THIS CONDITION BEGIN?

HAVE YOU SEEN A DOCTOR(S) FOR THIS CONDITION? □ YES □ NO

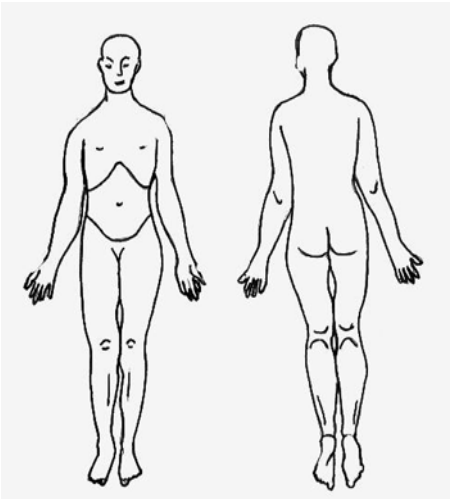
DOCTOR'S NAME AND SPECIALTY:

TYPE OF TREATMENT:

PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT, EVEN IF UNRELATED:

WRITE THE LETTERS ON THE PICTURE BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW:

A = ACHE
B = BURNING
N = NUMBNESS
O = OTHER
P = PINS AND NEEDLES
S = STABBING



Nobbe Family Chiropractic
2136 Vadalabene Dr, Ste B
Maryville, IL 62062-5828
(618) 288-5091

CLIENT NAME:
DATE:

HEALTH HISTORY

HAVE YOU HAD OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

□ **DENY ANY ISSUES**

□ ACUTE PAIN
□ ALLERGIES / SENSITIVITIES
□ ARTHRITIS: TYPE_____
□ ARTIFICIAL JOINT / DISORDER
□ BLOOD CLOTS
□ CANCER: TYPE_____
□ CARPAL TUNNEL SYNDROME
□ CHRONIC PAIN
□ CIRCULATORY DISORDER
□ CONTAGIOUS SKIN DISORDER
□ CURRENTLY PREGNANT
□ DECREASED SENSATION
□ DEPRESSION
□ DIABETES
□ EASY BRUISING
□ EPILEPSY
□ FIBROMYALGIA
□ HEADACHES / MIGRAINES
□ HEART CONDITION
□ HIGH / LOW BLOOD PRESSURE
□ HIV
□ INFECTIOUS CONDITION
□ LUPUS
□ MULTIPLE SCLEROSIS
□ OPEN SORE / WOUND
□ OSTEOPOROSIS
□ PTSD / PANIC / ANXIETY
□ SCOLIOSIS
□ SPINA BIFIDA
□ STROKE
□ SWOLLEN GLANDS
□ TENDONITIS
□ TMJ
□ VARICOSE VEINS

□ OTHER:_____ □ OTHER:_____

INJURIES: □ **DENY ANY ISSUES**

□ BACK / NECK INJURY
□ FRACTURE
□ SEVERE FALL
□ SOFT TISSUE INJURY

□ OTHER:_____ □ OTHER:_____

LIST PRESCRIPTION MEDICATION / VITAMINS:

LATE ARRIVAL / CANCELLATION

WE VALUE YOUR TIME AND STRIVE TO PROVIDE THE HIGHEST QUALITY CARE DURING EVERY APPOINTMENT. TO HELP US MAINTAIN THAT STANDARD, WE KINDLY ASK THAT YOU REVIEW THE FOLLOWING POLICY:

LATE ARRIVALS: IF YOU ARRIVE LATE, YOUR SESSION MAY BE SHORTENED IN ORDER TO STAY ON SCHEDULE FOR OTHER CLIENTS. **THE FULL SESSION FEE WILL STILL APPLY** REGARDLESS OF THE ACTUAL TIME USED.

CANCELLATIONS & RESCHEDULING: PLEASE PROVIDE AT LEAST 24 HOURS' NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. CANCELLATIONS WITH LESS NOTICE MAY BE SUBJECT TO A LATE CANCELLATION / NO SHOW FEE OR FULL SESSION CHARGE.

NO CALL / **NO SHOWS**: CLIENTS WHO MISS THEIR APPOINTMENT WITHOUT NOTICE WILL BE CHARGED THE FULL SESSION AMOUNT.

THANK YOU FOR YOUR UNDERSTANDING AND FOR HELPING US RESPECT EVERYONE'S TIME.

PAST DUE ACCOUNTS

AFTER 60 DAYS OF NON-PAYMENT, A $25 LATE FEE WILL BE ADDED AND COMPOUND MONTHLY.

IF NECESSARY, THE ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY AND A COLLECTION FEE OF 30% WILL BE ADDED TO YOUR BALANCE.

AS A LAST RESORT, LEGAL ACTION WILL BE TAKEN. ALL REASONABLE ATTORNEY AND COURT FEES INCURRED TO COLLECT PAST DUE ACCOUNTS WILL BE ADDED TO THE ACCOUNT AND THE PATIENT WILL BE RESPONSIBLE.

INFORMED CONSENT

I 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 THE SESSION, I WILL IMMEDIATELY INFORM THE THERAPIST SO THAT THE PRESSURE AND/OR TYPE OF STROKE MAY BE ADJUSTED TO MY LEVEL OF COMFORT. I UNDERSTAND THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION, AND THAT MASSAGE THERAPISTS ARE NOT QUALIFIED TO DIAGNOSE MEDICAL CONDITIONS, PERFORM ANY SPINAL MANIPULATIONS OR PRESCRIBE TREATMENTS. I HAVE STATED ALL KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS, WRITTEN AND VERBAL, HONESTLY. I AGREE TO KEEP THE MASSAGE THERAPIST UPDATED WITH ANY CHANGES IN MY MEDICAL PROFILE AND UNDERSTAND THAT THERE SHALL BE NO LIABILITY TO THE THERAPIST IF I FAIL TO DO SO.

CLIENT NAME (PLEASE PRINT):	RELATIONSHIP TO CLIENT:
SIGNATURE:	DATE:

EMERGENCY CONTACT

NAME:	PHONE NUMBER:

NOBBE FAMILY CHIROPRACTIC, 2136 VADALABENE DRIVE, SUITE B, MARYVILLE, ILLINOIS, 62062-5828

THANK YOU FOR CHOOSING NOBBE FAMILY CHIROPRACTIC