TRUE NORTH CHIROPRACTIC CENTER

Revealing Your Path to Exceptional Health!

Massage Intake form

Name _____ Birthdate ___-___-___Age _____

Address _____ City _____

State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact _____ Phone # _____

Have you had a massage before? ❑ No ❑ Yes

Email address _____ Can we email or text monthly specials? ❑ Yes ❑ No

❑ Yes ❑ No	Have you been in an auto accident in the last year? If yes When_____
❑ Yes ❑ No	Any slips, trips or falls in the last month?
❑ 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	If "yes" to previous question, are you taking medication for this?
❑ 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 diseases?
❑ Yes ❑ No	Do you have osteoporosis?
❑ Yes ❑ No	Do you have any allergies?
❑ Yes ❑ No	Do you bruise easily?
❑ Yes ❑ No	Have you had any broken bones 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	Have you ever had surgery? _____
❑ Yes ❑ No	Do you have any other medical conditions or are you taking any medications I should know about?

Comments:

_____

- 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 his staff to render care as deemed appropriate for me and/or my child.
- Person responsible for this account if other than the patient? _____
- For my balance my preferred method of payment is: ❑ Cash ❑ Check ❑ Credit Card

_____

Patient / Parent Signature Date

205 Brooks Ave N.
Thief River Falls, MN 56701
www.TrueNorthChiroCntr.com
TrueNorthChiro@Outlook.com
Ph: (218) 689-5001
Fax:(218) 319-7068

Cancellation Policy

We understand that unexpected events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 Hour Advance Notice

When cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged a $30 rescheduling fee for your missed appointment.

No-Shows

Initials_____

No Call within 24 hours or "no show" will be charged the full amount for your "missed" appointment.

Late Arrivals

Initials_____

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment given, **you will be financially responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

Patient Name:_____

Patient Signature:_____ Date:_____