MASSAGE THERAPY

Confidential Patient Information

fauntleroychiropractic

ABOUT YOU

Today's Date	
Name	
SSN	☐M ☐F
Birth date / /	Age
Home Address	#
City St	Zip
☐Single ☐Married ☐Divorced ☐Widow ☐Separated	
Hm #	
Wk#	
Occupation	
Employer	
Who referred you?	

BILLING INFO

☐ Cash	☐ Medical Insurance	☐ Medicare
☐ Workers Comp	☐ Auto Accident	☐ Other

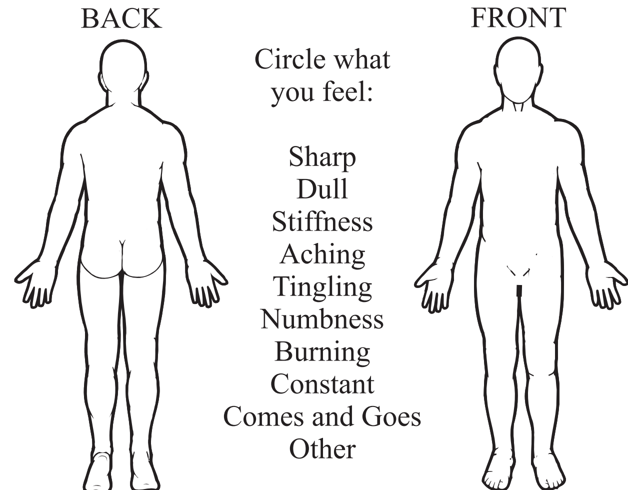
INSURANCE

Insurance Co. Name	
- please provide your insurance card for our front desk to copy.	
Ins. Co. Phone #	
Insured's Name	Relation
Chiropractic Coverage	☐Yes ☐No

CONTACT ME

Please contact me in any way necessary, EXCEPT as noted below:

COMPLAINTS (Please circle areas)



How often do you experience this?
Rate above on a 1-10 scale (10 most)
When did this condition first develop?
What caused this condition?
Is this the first time?
Has the problem been getting worse, better, or staying the same?
What makes it worse?
What have you done to help yourself?
Other doctors seen for this:

THANK YOU

The above information is correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. All fees are payable at the time of service, unless other arrangements are made in advance. I hereby authorize Fauntleroy Chiropractic Clinic to release to my insurance carrier any information required for my claim.
Patient Signature
Date

Fauntleroy Chiropractic Clinic 4520 Fauntleroy Way SW West Seattle, WA 98126 206/932-6605 fax 933-6999

Massage Therapy

Name ____ Date ___________________________

What is your major complaint? ____

Yes	No	
❒	❒	Have you ever had a professional therapeutic massage?
❒	❒	Do you wear dentures?
❒	❒	Do you have skin problems or allergies? If so, please list _______________________________
❒	❒	Are you pregnant? If so, how far along? ____
❒	❒	Do you take medication? If so, please describe _____________________________________
❒	❒	Have you ever had surgery? Describe ____
❒	❒	Have you suffered a significant injury recently? If yes, please describe ____________________
❒	❒	Do you have varicose veins or blood clots?
❒	❒	Do you have arthritis?
❒	❒	Do you have heart problems? ____
❒	❒	Do you have high/low blood pressure?
❒	❒	Do you have any spinal problems? ____
❒	❒	Do you have any infectious/contagious disease?
❒	❒	Do you have any areas that require special attention? _____________________________
❒	❒	Do you have any other medical conditions that your practitioner should be aware of?

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I understand that massage is given here for the purpose of relief from muscular tension, spasm or pain, stress reduction, and/or for increasing circulation or energy flow.
I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.
I have stated all my known medical condition and will update the massage practitioner of any changes in my health status.
I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if, for any reason, I suspend or terminate my treatment, any fees or professional services rendered me will be immediately due and payable. I further understand and agree that if my bill must be turned over to collections for nonpayment, any additional fees necessary for collection will be my responsibility.
I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment. I further authorize payment of medical benefits to Fauntleroy Chiropractic.
If you are sick, do not get a massage. If you are likely contagious (cough, sore throat, mucous, etc), it is not appropriate to be in close and extended proximity with a massage provider for at least 48 hours. Inform the office ASAP if you are scheduled for a massage but feel ill. *Initial:* ______
Finally, I understand that **24 hour notice must be given to cancel an appointment**. If I fail to give 24 hours notice, I understand I am responsible for a **$30 missed appointment fee** – payable immediately.
Initial: ______

Patient Signature ____ Date __________________________