# HANSON
CHIROPRACTIC & MASSAGE

## Massage Intake Form

### Personal Information

Name ______________________ Phone (day) ______________ (evening) ______________

Address ______________________ City/State/Zip ______________________ DOB __________

Occupation ______________________ Employer ______________________

Email ______________________ Primary Physician ______________________

Emergency Contact ______________________ Relationship ______________ Phone ______________

Claim/ID#? ____________________________________________

### Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: ______________________

______________________

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ______________________

Any high risk factors? ______________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain: ______________________

What makes it better? ______________________

______________________

What makes it worse? ______________________

______________________

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ______________________

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Including date, explain any surgeries, accidents or injuries:

______________________

______________________

______________________

______________________

### Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain ______________________

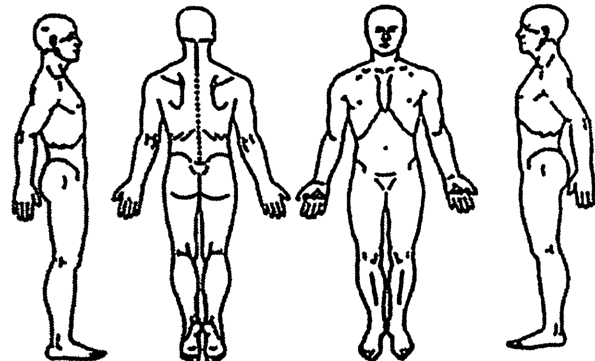
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ______________________

What are your goals for this treatment session?

______________________

Please circle any areas of discomfort



*By signing below you agree to the following.*

*I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.*

*Client Signature* ______________________ *Date* __________

# MASSAGE NO SHOW/MISSED APPOINTMENT POLICY

We, at Hanson Chiropractic, understand that sometimes you need to cancel or reschedule your appointments due to illness or emergencies. If you are unable to keep your appointment, please call us as soon as possible with at least 24-hours notice.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an email or phone call reminder is made/attempted to you prior to your scheduled appointment, and a text reminder is sent to your 24 hours prior. However, it is the responsibility of the patient to arrive for their appointment on time.

**PLEASE REVIEW THE FOLLOWING POLICY:**

1. Please cancel your appointment with at least 24 hours' notice. There is a waiting list to see the massage therapists at Hanson Chiropractic and whenever possible, we like to fill the canceled slots to shorten the waiting time for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you have one (1) or more "No-Show/Missed" appointments, you will be charged $45 no show fee each time. We require a card on file, which will be charged in the event of these missed appointments.

Patient Initials: __________

***I have read and understand*** the Hanson Chiropractic No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Hanson Chiropractic appropriately if I have difficulty keeping my scheduled appointments.

____________________________________ ________________

Patient Name Date

______________________________________ ________________

Patient Signature or Parent/Guardian if minor Date