ALAMOGORDO CHIROPRACTIC

1909 Cuba Avenue, Suite 1 • Alamogordo, NM 88310 • 575-214-2800

MASSAGE THERAPY CONFIDENTIAL PATIENT HEALTH RECORD

Name:	______________________	Today's Date:	______________________
Address:	______________________	Telephone Number:	______________________
City, State, Zip:	______________________	Date of Birth:	______________________
Email Address:	______________________	Referred by:	______________________
Occupation:	______________________	Health Insurance Carrier:	______________________
Emergency Contact:	______________________	Telephone Number:	______________________

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage?	□ Yes	□ No	
What kind of pressure do you prefer?	□ Light	□ Medium	□ Firm
How much water do you drink daily?	□ 2 – 4 glasses	□ 5 - 7 glasses	□ 8 + glasses
What are your massage or bodywork goals?	□ Therapeutic	□ Other ______________________	

Please mark all current and past conditions:

□ Contagious Skin Condition	□ Open Sores or Wounds	□ High/Low Blood Pressure	□ Stress
□ Bruise Easily	□ Blood Clots/Deep Vein Thrombosis	□ Recent Accident/Surgery	□ Recent Fracture
□ Joint Replacement	□ Sprains/Strains	□ Carpal Tunnel	□ Fibromyalgia
□ Allergies/Sensitivities	□ Heart Condition	□ Pacemaker	□ Circulatory Disorder
□ Varicose Veins	□ Arthritis/Joint Disorder	□ Tennis Elbow	□ Frozen Shoulder
□ Osteoporosis	□ Epilepsy/Seizures	□ Headaches/Migraines	□ Diabetes
□ Numbness	□ Back/Neck Issues	□ Pregnant/What Trimester ______	

Do you have tension or soreness in a specific area? Please specify: ______________________

Please explain any checked conditions listed above and anything else you think your therapist should be aware of: ______________________

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Please list any medications prescribed or you are currently taking you think your therapist should be aware of: ______________________

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Disclaimer

This place of business will not be held liable for any injury or condition that arises from application of massage despite Completion of this form. The form is intended as an assessment tool only and serves as a guide for the application of massage; not for medical treatment or medical assessment. Draping will be used during this session. Only the body area being worked on will be uncovered. Breast massage on female clients will not be performed without written consent of the client prior to massage. Clients under the age of 18 must have a parent or legal guardian present to provide signatures for authorizations for the therapeutic massage session and must be seen with a same gender massage therapist or parent must be present in the massage session.

Cancellation Policy

By signing this form you agree that if you need to cancel or reschedule an appointment, you will have until the close of the business day before your Appointment to cancel to avoid being charged a fee. Any cancellations, not showing up to your scheduled appointment and changing your appointment the same day will result in a full charge of the session.

Financial Policy

A policy of this office is to extend to our patients the courtesy of assigning your insurance benefits to us. This assignment begins with receiving a copy of your insurance card. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. If there is deductible, co-pay, or other out of pocket expense, I agree to pay my portion as services are rendered. I understand that I am ultimately responsible for payment in full at this office. In the event default in payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred.

I, ______________________, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance or deductible not paid for by my insurance company. However, I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

I, the undersigned, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, increasing circulation, energy flow and overall better health through therapeutic means. I agree to inform my massage therapists immediately of any change in the conditions stated above. I acknowledge that this information is confidential and intended for review by massage therapist; that medical referral may be requested of me; and that Hammel Chiropractic is not liable for the management of any condition. I further understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. If uncomfortable for any reason, a client may end the session. I also understand that any illicit or sexually suggestive remarks or advances made by myself will result in immediate termination of this session, and I will be liable for full payment of the appointment. I also agree that the information stated above is true and correct to the best of my knowledge.

Patient's Signature: ____ Date: ____________________

Or Guardian Signature: ____ Date: ____________________

Consent to Treatment of Minor: By my signature below, I hereby authorize ___________________________ to administer massage, bodywork, or somatic therapy techniques to m y child or dependent as they deem necessary.

Signature of Parent/Guardian: ____Date: ____________________