MASSAGE & CHIROPRACTIC INTAKE FORM

BARKLEY MASSAGE & CHIROPRACTIC

2930 Newmarket St. Ste 115. Bellingham, WA 98226

P: 360-656-5131 info@barkleyhealth.com

Today's Date:_____

PATIENT INFORMATION

Name _____Preferred Name_____

Gender ☐ M ☐ F Date of Birth _____/_____ /_____ Age _____ Height _____ Weight _____

Address _____

Home Phone_____ Cell Phone_____

Email _____

Occupation & Employer _____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

Referred by? _____

FINANCIAL INFORMATION

☐Self-Pay (Cash/Check/Card) ☐ Health Insurance ☐ Auto Accident ☐ LnI

Insurance info:_____

_____

HISTORY OF CURRENT CONDITION

Describe main complaint (if any):_____

Was the onset sudden, gradual or part of an ongoing chronic problem?_____

Does anything make the complaint better? _____

Does anything make the complaint worse? _____

Quality of the pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:_____

Does this pain radiate/extend/refer to any areas of your body? No / Yes (Describe):_____

Severity of the pain (10 = the worst pain you've ever had): 1 2 3 4 5 6 7 8 9 10

How frequent is the pain? *Off & On / Constant / Only Certain Movements*

What was the Date of Injury (if any):____/____/____

How long has the condition been going on?_____

Has it changed since the onset? (better, the same, worse):_____

Have you had this condition before? (if yes please explain):_____

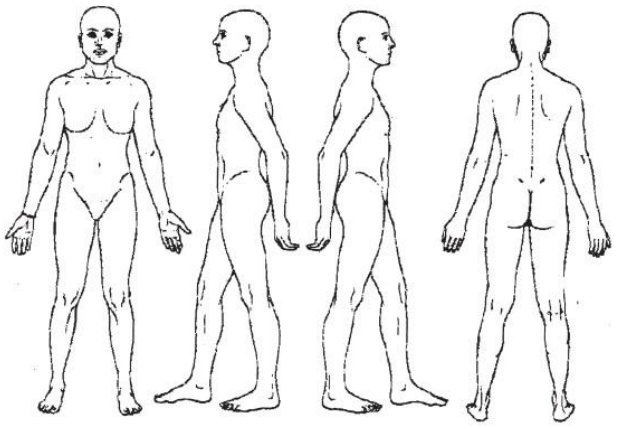
Which activities are being affected by this condition? (circle) *Work Recreation Sleep Household-Chores*

FOR THIS CURRENT CONDITION, HAVE YOU:

Received any other treatment? _____

Any diagnostic testing? X-Ray / MRI / CT / Other:_____

CIRCLE THE AREAS WHERE YOU HAVE PAIN…



HEALTH HISTORY

***CURRENT MEDICATIONS*:** _____

PAST HEALTH HISTORY *(please list anything in the past and when it happened):*

Surgeries: _____

Major Traumas/Injuries: _____

Major Hospitalizations: _____

FAMILY HEALTH HISTORY

List relevant major health problems of immediate relatives: _____

Deaths in immediate family: *(cause and at what age?)* _____

REVIEW OF SYSTEMS

Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ pregnancy If yes, how many months? _____
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorders
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ tennis elbow

Please explain any condition that you have marked above: _____

Patient signature: _____ **Date:** _____

HIPPA NOTICE

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If there is anyone you do not want to receive your medical records, please inform our office.

Patient signature:_____

INFORMED CONSENT TO MASSAGE THERAPY (Please sign even if you're not receiving massage, just in case you do later)

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 this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Patient signature:_____

INFORMED CONSENT TO CHIROPRACTIC CARE (Please sign even if you're not getting chiropractic, just in case you do later)

I hereby request and consent to chiropractic adjustments by Barkley Massage & Chiropractic's Physicians. I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient signature:_____

CANCELLATION POLICY

We charge an ADDITIONAL 100% of the scheduled service fee if you cancel/reschedule AFTER 2PM THE DAY BEFORE, or do not show up to your appointment.

Patient signature:_____

CONSENT TO TREAT A MINOR (IF APPLICABLE)

I (***full name of legal Parent or Guardian***) _____ am the legal parent or guardian of the above patient and consent to chiropractic treatment at Barkley Massage & Chiropractic.

Parent or guardian signature:_____