

MASSAGE & CHIROPRACTIC INTAKE FORM

BARKLEY MASSAGE & CHIROPRACTIC: 2930 Newmarket St. Ste 115. Bellingham, WA 98226 / 360-656-5131

Today's Date: _____

PATIENT INFORMATION

Name _____ Preferred Name _____

Gender M F Other _____ Date of Birth ____/____/____ Age _____ Weight _____

Address _____ Zip Code _____

Cell Phone _____ Home Phone (if different) _____

Email _____

Occupation & Employer _____

HOW DID YOU FIND OUT ABOUT US?

Paid Google Advertisement

Free Google Advertisement

Yelp

Referred by friend/family

Walked-by/Location

Doctor referral

Promotion

INSURANCE INFORMATION

No-Insurance/Self-Pay

Health Insurance

Auto Accident/PIP

Lni/Work Injury

PIP/ Lni Info _____

WHAT KIND OF MASSAGE DO YOU WANT AND WHERE DO YOU WANT THE THERAPIST TO FOCUS MOST OF THE MASSAGE? (Massage Clients Only)

Light-Pressure/Relaxation

Moderate-Pressure

Deep Pressure

Neck & Shoulders

Middle Back

Low Back

Extremities

HISTORY OF CURRENT CONDITION

Describe main complaint (if any): _____

Describe the onset: *Sudden / Gradual / Part of an ongoing chronic problem / Other:* _____

What makes the complaint BETTER? _____

WHAT makes the complaint WORSE? _____

Describe 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? _____

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

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

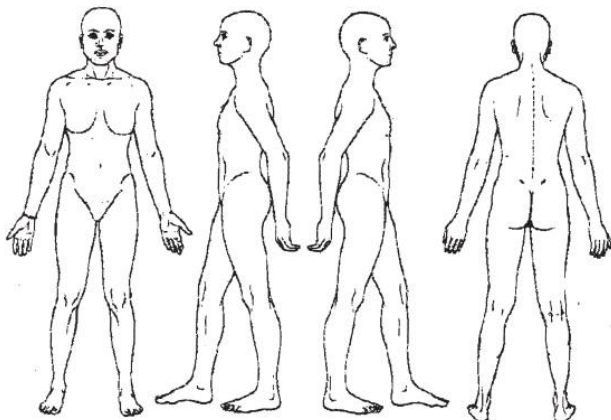
Which activities are affected? (circle) *Work / Recreation / Sleep / Household-Chores*

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:

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

Please explain any condition that you have marked above: _____

Patient signature: _____ **Date:** _____

OUR CANCELLATION POLICY

MASSAGE

We charge for the appointment in full (to your card on file) if you cancel/reschedule AFTER 2PM THE DAY BEFORE, or do not show up to your appointment. We do this 15 minutes after your missed appointment start time.

CHIROPRACTIC

We charge \$50 (to your card on file) if you cancel AFTER 2PM THE DAY BEFORE, or do not show up to your appointment. We do this 15 minutes after your missed appointment start time. You may call and move your appointment around the same day without additional charge, as long as we have space.

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: _____

HIPPA NOTICE (OUR PRIVACY POLICY AND HOW WE PROTECT YOUR HEALTH INFORMATION)

I understand and agree to allow this massage & chiropractic office to use my patient health information for the purpose of treatment, insurance billing and coordination of care. I understand that treatment and care may be discussed in the front waiting area and upon request you have the right to discuss these matters in a closed room only. If there is an insurance company you do not want to receive your medical records, please inform our office. Other than to insurance companies, your medical records will only be released with your prior written consent.

Patient signature: _____

INFORMED CONSENT TO MASSAGE THERAPY

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

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: _____

Insurance Billing Policy

- We bill insurance at Barkley Massage & Chiropractic.
 - Massage: PIP and Lnl
 - Chiropractic: All health insurance
- When insurance doesn't pay it is your responsibility.
- Insurance claims over 60 days old become patient responsibility and will be charged to a debit or credit card that must be kept on file.
- Accounts past 60 days old will be charged on the 1st and the 15th of every month.
- We require a photocopy of two (2) forms of payment that we can charge. One debit card and one credit card.
- If we need to charge your card, we will email you a billing statement explaining the charges and then immediately process the payment. We will not call you over the phone.

I understand that in the event my health insurance, car insurance or workers' compensation insurance denies my claim or for any reason does not pay within 60 days that I am responsible for payment and give permission for Barkley Massage & Chiropractic to charge one of the two cards on file.

Patient Name: _____

Patient Signature: _____

Date: _____