Massage Intro Form

Patient Name _____ Date of Birth: _____
Address _____ Home Phone _____
Email Address _____ Cell Phone _____
Previous Address (if less than 2yrs) _____
Emergency Contact Name: _____ Relationship: _____ Phone No. _____
Occupation: _____ How long _____ Work Phone _____
Employer Name and Address _____
Spouse Name _____ Spouse Employer _____
Insurance Subscriber's Name and Date of Birth _____
Insurance Subscriber's Social Security # _____ Policy # _____
Primary Care Physician _____ Phone _____
Referred By _____ Phone _____

Describe your current problem and how it began _____
_____

Is this □ work related injury □ auto related injury - If so, date of incident _____

Have you been treated previously for this condition? Y / N
If yes, by whom? (Doctor or hospital) _____ Release Date _____

Have you had X-Rays, MRI, CT Scan or other treatment for this injury prior to your visit today?
If so, list treatment rendered, location and date _____
_____

Have you had any previous surgeries, trauma, accidents, falls, etc.? If so, please explain: _____
_____

Are you currently on any medication? Y/N If so, please list _____
What is the medication for? _____

Do you have a family history of any of the following: □ Rheumatoid Arthritis
□ Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Check box if none of the conditions apply □

Past	Present		Past	Present		Past	Present	
[ ]	[ ]	Headaches	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Diabetes
[ ]	[ ]	Neck Pain	[ ]	[ ]	Heart Attack	[ ]	[ ]	Excessive Thirst
[ ]	[ ]	Upper Back Pain	[ ]	[ ]	Chest Pains	[ ]	[ ]	Frequent Urination
[ ]	[ ]	Mid Back Pain	[ ]	[ ]	Stroke	[ ]	[ ]	Smoking/Tobacco Use
[ ]	[ ]	Low Back Pain	[ ]	[ ]	Angina	[ ]	[ ]	Drug/Alcohol Dependence
[ ]	[ ]	Shoulder Pain	[ ]	[ ]	Kidney Stones	[ ]	[ ]	Allergies _____
[ ]	[ ]	Elbow/Upper Arm Pain	[ ]	[ ]	Kidney Disorders	[ ]	[ ]	Depression
[ ]	[ ]	Wrist Pain	[ ]	[ ]	Bladder Infection	[ ]	[ ]	Systemic Lupus
[ ]	[ ]	Hand Pain	[ ]	[ ]	Painful Urination	[ ]	[ ]	Epilepsy
[ ]	[ ]	Hip Pain	[ ]	[ ]	Loss of Bladder Control	[ ]	[ ]	Dermatitis/Eczema/Rash
[ ]	[ ]	Upper Leg Pain	[ ]	[ ]	Prostate Problems	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Knee Pain	[ ]	[ ]	Abnormal Weight Gain/Loss	[ ]	[ ]	Loss of Appetite
[ ]	[ ]	Ankle/Foot Pain	[ ]	[ ]	Abdominal Pain	[ ]	[ ]	Ulcer
[ ]	[ ]	Jaw Pain	[ ]	[ ]	Liver/Gall Bladder Disorder	[ ]	[ ]	Hepatitis
[ ]	[ ]	Joint Pain/Stiffness	[ ]	[ ]	General Fatigue	[ ]	[ ]	Muscular Incoordination
[ ]	[ ]	Arthritis	[ ]	[ ]	Visual Disturbances	[ ]	[ ]	Hormonal Replacement
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Dizziness	[ ]	[ ]	Pregnancy
[ ]	[ ]	Cancer	[ ]	[ ]	Tumor	[ ]	[ ]	Birth Control Pills
[ ]	[ ]	Asthma	[ ]	[ ]	Chronic Sinusitis			

Please check all of the following that apply to you. **Check box if none of the conditions apply.** □

□ Alcohol/Drug Dependence
□ Urinary Problems
□ Recent Fever
□ Diabetes
□ High Blood Pressure
□ Stroke (Date) _____
□ Marked Morning Pain/Stiffness
□ Pain at Night
□ Dizziness/Fainting
□ Visual Disturbances
□ Epilepsy/Seizures
□ Heart Problems
□ Tobacco Use (Type/Freq.) _____
□ Prostate Problems
□ Menstrual Problems
□ Currently Pregnant, # Weeks _____
□ Taking Birth Control Pills
□ Abnormal Weight □ Gain □ Loss
□ Corticosteroid Use (Cortisone, Prednisone, etc.)
□ Pain Unrelieved by Position or Rest
□ Numbness in Groin/Buttocks
□ Osteoporosis
□ Cancer/Tumor (Explain) _____
□ Other Health Problems (Explain) _____

Strelcheck Chiropractic and Massage Clinic Policies

1. Payment is due at the time of service, or in accordance with my financial agreement.
2. I understand that an insurance contract is between the patient and the patient's insurance company. Coverage for Chiropractic care varies from company to company and policy to policy. SCC, Inc. as a courtesy and in an effort to serve our patients to the best of our ability will file the insurance claims on behalf of the patient, however. It is the patient's ultimate responsibility to keep the account current. SCC, Inc. cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.
3. Patients involved in litigation (lawsuits) are, as others, ultimately responsible for their treatment charges.
4. We reserve the right to bill for missed appointments.
5. I agree to pay all amounts due for services rendered by the Strelcheck Chiropractic Clinic, Inc. (SCC, Inc.) upon rendering of services and further agree to reimburse said clinic for all fees and costs incurred in the collection of such amounts, including, but not limited to reasonable attorney fees. I understand that if my bill is not paid, my information will be given to a collection agency.
6. I authorize release of my medical information necessary to process my claims. I authorize payment of benefits to Strelcheck Chiropractic Clinic for services rendered to me.
7. X-rays are the property of Strelcheck Chiropractic Clinic.

My signature is an acknowledgement that I have read the policies above and agree to abide by the same.

Patient Signature: _____ Date: _____

Our professional and personal concern is with just two things; your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help. Thank you for your time and effort in providing us with this information.

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

MASSAGE CLIENT AGREEMENT

I, _____, understand that massage therapy given is for the purpose of stress reduction/management, muscular tension/spasm relief and/or increasing circulation and energy flow.

I understand that massage therapists **do not diagnose** illness, disease or any other physical or mental disorder. Massage therapists **do not prescribe** medical treatment or pharmaceutical, nor do they perform any spinal manipulations. I have been informed that massage therapy is not a substitute for medical or chiropractic examinations and/or diagnosis. It has been recommended that I see a chiropractor or medical physician for any physical ailment that I might have.

Because massage therapists must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

With all this in mind, I agree to have massage therapy and hold the therapist harmless for any problems that may arise as a result of my massage sessions.

_____ _____
Signature Date

_____ _____
Witness Date

PLEASE BE PROMPT FOR YOUR APPOINTMENTS – THANK YOU

CANCELLATION/MISSED APPOINTMENT POLICY

Office policy provides that massage appointments cancelled with less than a 24 hour notice or missed/no show will result in 50% of the scheduled session fee assessed to my account. _____ Client Initials

ANY INAPPROPRIATE SEXUAL GESTURES WILL RESULT IN THE SESSION ENDING IMMEDIATELY WITH FULL PAYMENT REQUIRED.

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NAME:_____ **DATE:**_____

WORKING TOGETHER TO ACHIEVE MORE

As we strive to create mutually beneficial relationships for our patients, please share with us your health care providers name, address and phone number. We would like to invite him/her to be a part of our Strelcheck Preferred & Valued Physician Program.

Patient Referral Name _____#_____Town Located _____
Family Physician _____#_____Town Located _____
OB-GYN _____#_____Town Located _____
Dentist _____#_____Town Located _____
Specialist _____#_____Town Located _____
Other Health Care Professionals _____#_____Town Located _____

HEALTH CONTINUUM

SEVERE SYMPTOMS	MODERATE SYMPTOMS	MILD SYMPTOMS	REPORTING SOME RELIEF	FEELING BETTER	SYMPTOMS GONE	FEELING GREAT	ENJOYING OPTIMUM HEALTH

Please mark "A" on Health Continuum showing how you feel today and mark "B" showing where you want to be.

Please check any boxes below that you are interested in or feel you would benefit from in achieving your health goals. The doctor will review and make recommendations.

☐ **I am not interested in any of these at this time**

MASSAGE THERAPY
☐ Stress Relief
☐ Deep Tissue/Therapeutic
☐ Increase circulation
☐ Energy work
☐ Lymph draining
☐ Other _____

PHYSICAL THERAPY
☐ Increase strength/energy
☐ Increase range of motion/Stretching
☐ Traction/De-compression/Flexion-Distraction
☐ Pain control/E-stim
☐ Scar tissue/adhesion breakdown
☐ Physiotape/Kinesotaping
☐ Therapeutic ultrasound
☐ Stability/Proprioceptive/Balance training
☐ Posture correction
☐ Other _____

SUPPORTS
☐ Orthotics
☐ Lumbo/Sacral Belt
☐ Extremity Brace
☐ Topical Analgesic/Liquid Ice & Liquid Heat
☐ Ice Packs
☐ Leg Spacer
☐ Lumbar Support
☐ Other _____

NUTRITION
☐ Weight loss issues
☐ Energy issues
☐ Sugar handling/Diabetes issues
☐ Digestion issues
☐ Allergy issues
☐ Immune system issues
☐ Detox
☐ Sleep issues
☐ Hormonal/Reproductive issues
☐ Other _____

NUTRITION CURRENTLY TAKING ☐NONE
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

GENERALIZED HEALTH
☐ Blood Testing/Urine Analysis
☐ MRI/CT Scan
☐ Yoga/Pilates/Cross-training/Aerobics
☐ Natural Childbirth Classes
☐ Post X-rays