

# Massage Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Email \_\_\_\_\_ Primary Physician \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## 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.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

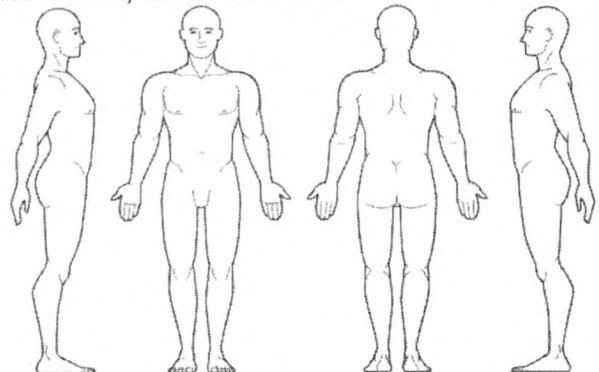
Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Massage Information

Have you had a professional massage before? ☐ yes ☐ no  
What type of massage are you seeking?  
☐ Relaxation ☐ Therapeutic/Deep Tissue  
Other \_\_\_\_\_  
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 \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

# Policy Notification

We appreciate that you've chosen us for your massage and bodywork needs. To provide the best service possible to our clients we have implemented the following policies.

## Cancellation Policy

We respectfully ask that you provide us with a 24 hour notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointment without providing a 24 hour notice we are often unable to fill that appointment time. This is an inconvenience to your therapist and also means our other clients miss the chance to receive services they need. For this reason, you will be charged 50% of the service fee for the first missed session and 100% of the service fee for each session after that. We also reserve the right to require a credit card number to be given to book future appointments so that appropriate fees may be charged if a late cancellation does occur.

We understand that emergencies can arise and illnesses do occur at inopportune times. If you have a fever, a known infection, or have experienced vomiting or diarrhea within 24 hours prior to your appointment time, we request that you cancel your session. Inclement weather may also result in the need for late cancellations. We will do our best to give advanced notice if we are closing or need to cancel due to bad weather and we ask you to do the same. Please do not risk your own safety trying to make your appointment. Late cancellation due to emergency, illness, or inclement weather will generally not result in any missed session charges, but this is determined on a case-by-case basis.

## Late Arrival Policy

We request that you arrive 5-10 minutes prior to your appointment time to allow time to fill out any required paperwork as well as answer any intake questions your therapist may have. We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so we can do our best to accommodate you. Appointment times are reserved for each client, so oftentimes we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full service fees will be charged even when sessions are shortened due to late arrival. In return we will do our best to be on time, and if we are unable to do so we will add time to your session to make up for our late arrival or adjust the service charge accordingly.

## Inappropriate Behavior Policy

Massage therapy is for relaxation and therapeutic purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity and you will be treated the same in return.

By signing below, you agree to abide by these policies.

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Client Signature

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Date

## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your **back pain** and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your **back pain**?

No pain

Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your **back pain** interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your **back pain** interfered with your ability to take part in recreational, social, and family activities?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your **back pain**?

Have made it no worse

Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your **back pain** on your own?

Completely control it

No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:** \_\_\_\_\_



## NECK BOURNEMOUTH QUESTIONNAIRE

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain

Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse

Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it

No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Examiner \_\_\_\_\_

Date \_\_\_\_\_

Score \_\_\_\_\_ (70)

Inmates or individuals in custody. If you are an inmate of a correction institution or other custody of the law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with healthcare; 2) to protect your health and safety or the health and safety of others, or, 3) for the safety and security of the correctional institution.

### **Your Rights**

You have the following rights regarding Health Information we have about you:

**Right to inspect and copy:** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our privacy Officer.

**Right to Amend:** If you feel that Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing, to our Privacy Officer.

**Right to Accounting of Disclosure:** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of Disclosures, you must make your request in writing to our Privacy Officer.

**Right to Request Restrictions:** You have the right to request restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have the right to request a limit on Health Information we disclose to someone involved in you care or the payment for your care., like a family member or spouse. To request a restriction, you must make a request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication:** you have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable request.

**Right to a Paper Copy of This Notice:** you have a right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

**Changes to This Notice:** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future, we will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**Complaints:** if you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

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Patient Signature

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Date

# Dorland Chiropractic Clinic

713 SE Everett Mall Way Suite #B  
Everett, WA 98208

## **Patient Messaging Consent**

By supplying my home number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

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Print Name

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Date

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Signature

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Cell Phone Carrier