

# Marr Chiropractic Client Intake Form

## Personal Information:

Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**The following information will be used to help plan safe and effective massage sessions.  
Please answer the questions to the best of your knowledge.**

Date of Initial Visit \_\_\_\_\_

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? \_\_\_\_\_

2. Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain \_\_\_\_\_

3. Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain \_\_\_\_\_

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe \_\_\_\_\_

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe \_\_\_\_\_

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

if yes, how do you think it has affected your health?

Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other \_\_\_\_\_

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain

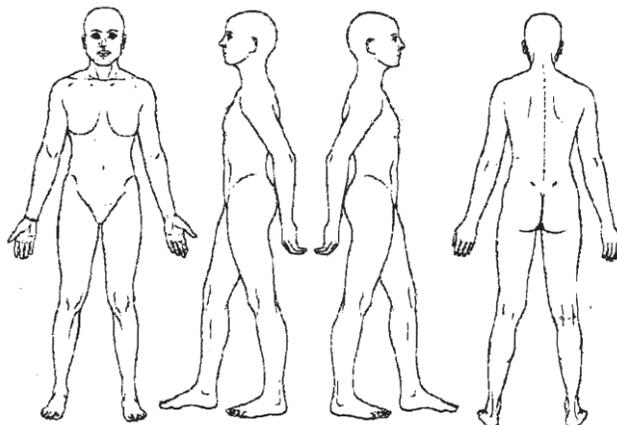
or other discomfort? Yes No

If yes, please identify \_\_\_\_\_

10. Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain \_\_\_\_\_

Circle any specific areas you would like the  
massage therapist to concentrate on  
during the session:



# Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain \_\_\_\_\_

12. Do you see a chiropractor? Yes No If yes, how often? \_\_\_\_\_

13. Are you currently taking any medication? Yes No

If yes, please list \_\_\_\_\_

14. Please check any condition listed below that applies to you:

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

Please explain any condition that you have marked above \_\_\_\_\_

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? \_\_\_\_\_

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, \_\_\_\_\_ (print name) 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.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Massage Therapist \_\_\_\_\_ Date \_\_\_\_\_

# MARR CHIROPRACTIC

70 S. Ortonville Rd  
Ortonville, MI 48462  
248-627-8264  
marrchiro@aol.com

## Massage Appointment Patient Policies

Client Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

**Reservations** - We suggest making reservations in advance to secure your preferred time and date.

You will be asked for a credit card during the reservation scheduling - this is required to hold your reservation(s). Nothing will be charged on this card unless you do not show, or cancel outside of the cancellation policy.

If you wish to pay with cash, gift certificate, or another credit card when you arrive, you have the choice to do so.

**Late Arrivals** -Your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "FULL" session.

**Cancellations/No Shows** - Cancellations must be made, by calling the office, at least 24 hours in advance. ***If less than 24 hours a 50% charge of your scheduled service will be billed. Failure to cancel, no shows, and no calls, will result in a full service (100%) fee charge.*** { \_\_\_\_\_ } *Please initial*

We understand emergencies and illnesses occur. In the event of reasonable unexpected life events or illness, at the discretion of the office, we may waive this policy. Feel free to call and reschedule your appointment, because we do want to work with you. This policy is only put in place to encourage common courtesy.

**Forms of Payment** – We accept Cash, Visa, MasterCard, American Express, Discover, Gift Certificates and Personal Checks (no out of state checks will be accepted), for payment of services.

Any returned Checks (NSF) will be subject to a \$35.00 Fee. NSF fees may change without notice.

**Gratuities** – Gratuities are not included in the price of your session and are left up to your discretion. Any gratuities are greatly appreciated by your massage therapist!

Please note that we cannot add tips to credit card payments.

**Conduct** - We reserve the right to refuse service to anyone that appears to be under the influence of alcohol or other substances. Inappropriate behavior toward our staff will result in immediate termination of your session and you will be liable for full payment of the scheduled appointment.

**Communicate** – It is your responsibility to update the massage therapist with any changes in your health status each time you receive a massage. It is important for you and your therapist to communicate clearly. Any comments about pressure, technique used by the therapist etc., are strongly encouraged during your massage and are crucial to maximizing your experience. If you prefer to remain silent during the massage, we ask that you let the therapist know. Please don't hesitate to express any discomfort, as well as any preferences that

will make your experience more enjoyable and healing, such as the volume of the music, massage pressure, bed temperature, and room temperature. This is your time for rest, relaxation, and therapeutic benefits.

If you have long hair please tie it up, and all jewelry should be removed prior to treatment and placed in the bowl provided.

**Gift Certificates** - Gift cards as just as great to give as they are to receive. Gift Certificates are available for purchase at the office. ALL GIFT CERTIFICATES EXPIRE 1 YEAR FROM THE PURCHASE DATE.

I have read the above policies and have had any of my questions answered fully by a member of the Marr Chiropractic team.

Charge Card # \_\_\_\_\_ Exp: \_\_\_\_\_ CVV: \_\_\_\_\_

Date: \_\_\_\_\_ Signature : \_\_\_\_\_