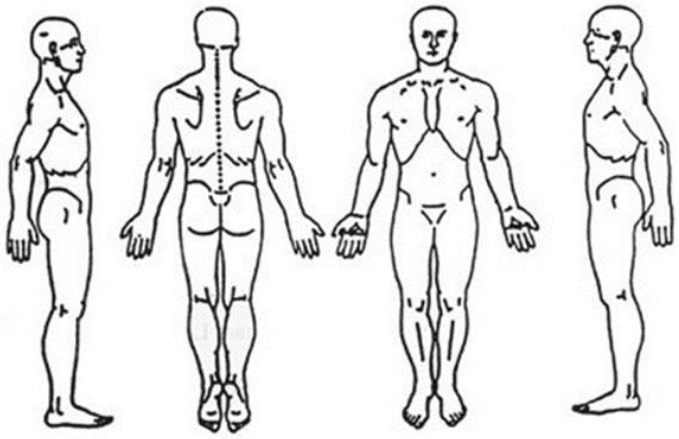
HEALTH + CHIROPRACTIC

Massage Patient Intake Form Date:_____

First name_____ Middle Initial_____ Last Name_____

Cell Phone _____-_____-_____



Approximate date this condition began _____

What caused this injury/condition? _____

Have you had any surgeries? YES NO

If yes, please explain: _____

Are you taking prescription medications? YES NO

If yes, please list: _____

Do you have an illness history– such as diabetes, cancer, blood disorder, high blood pressure, or progressive neurological diseases? YES NO

If yes, please explain: _____

CONSENT TO TREAT

I certify that I am the patient, or the legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information above to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient or guardian signature: _____