



Massage Client Registration and Health Information

Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Contact Ph#s - Day: _____ Evening: _____ Cell: _____

Emergency Contact Person: _____ Ph#: _____

Date of last visit with your doctor: ____/____/____ Occupation: _____

List current medications: _____

Have you ever received a massage or other type of body work before? Yes No Type _____

What is your reason for receiving a massage today? _____

Please check whether or not you currently have or have had any of the following:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Surgeries/Accidents |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Dentures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rashes | <input type="checkbox"/> TMJ Pain |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ruptured Disc | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Shingles | <input type="checkbox"/> Other _____ |

Please use the space below to provide additional information concerning those items checked or any other health-related conditions you currently have or have had in the past.

Your massage session will involve the use of oils, lotions and possibly hot and/or cold packs requiring that you to remove most of your clothing. During this time, you will be draped with linens for warmth and privacy. Only the specific area being treated will be undraped. Please inform the massage practitioner if you prefer to remain clothed during your sessions and we will make appropriate accommodations for you.

I understand that the massage given by Mercer Wellness Chiropractic's licensed massage practitioners is for purposes of relaxation, stress reduction, relief from muscle pain or spasm, and/or for increasing circulation. I further understand that Mercer Wellness massage practitioners do not diagnose illnesses or prescribe medical or pharmaceutical treatment. It has been made clear to me that massage is not a substitute for a medical examination and it is recommended that I contact a licensed health care provider for any medical or health condition. I also understand bruising or flu-like symptoms may occur after treatment.

It is my choice to receive massage therapy and I have provided accurate information concerning all past and current health conditions. I agree to report any changes in my health as they arise.

Patient's Signature: _____ Date: _____

Signature of Parent/Guardian, if under 18: _____ Date: _____

IF WE ARE BILLING YOUR INSURANCE FOR MASSAGE SERVICES, PLEASE READ AND SIGN.

Most insurance policies cover massage therapy. We do accept most insurance policies and will verify your coverage and benefits. Verification of these benefits is NOT a guarantee of payment from your insurance carrier. Every plan varies and may require you to satisfy deductibles, coinsurance and/or copays.

I hereby authorize Mercer Wellness Chiropractic to charge my insurance carrier for any massage services rendered and accept full payment responsibility for any charges not paid for or covered by my insurance.

Patient's Signature: _____ Date: _____

At Mercer Wellness Chiropractic, we understand that unanticipated events occur in everyone's life. Unforeseen events such as flight delays, car problems, traffic considerations, business meetings, and project deadlines, are just a few reasons why one might consider canceling a massage appointment.

In our commitment to provide a unique and outstanding massage experience to all of our patients and out of consideration for our massage practitioner's time, we have adopted the following policies:

(Initial Here) **ARRIVAL TO THE CLINIC** -Please arrive for your appointment 15 minutes prior to the scheduled start time. This allows you the time to fill out the appropriate forms, change and prepare for the service. All services offered have a specific time schedule and early arrival allows for a relaxed and unhurried experience. If late arrival is inevitable, your service may be shortened in order to keep on schedule.

(Initial Here) **CANCELLATION POLICY** -We have a 24-hour cancellation policy. At our discretion, we will require a credit card to book/hold your appointment. Your credit card will not be charged if the appointment is cancelled or rescheduled 24 hours prior or you show up for your scheduled appointment.

If you are booking your massage within 24 hours of the actual appointment, cancellations will not be allowed and you will be charged the full amount of the appointment if missed.

(Initial Here) **LATE ARRIVAL POLICY** -As a courtesy to our other patients and staff, if you arrive 20 minutes after your scheduled appointment, without properly notifying us in advanced of your tardiness, your appointment will be automatically cancelled and charged according to our cancellation policy. We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule will allow, we may be able to accommodate a partial or full appointment. This will be at our discretion and only with proper, advanced notification of your late arrival.

(Initial Here) **SEXUAL MISCONDUCT** -Sexual misconduct is forbidden. Patients understands that any illicit or sexually aggressive remarks, advances or gestures will result in the immediate termination of the session and the patient will be liable for full payment of the scheduled appointment.

These policies were adopted to ensure that the massage practitioner's time, the clinic and its efforts be respected, as well as your scheduled service be a stress-free and relaxing experience.

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR ADVANCED NOTICE WILL BE CHARGED THE FULL APPOINTMENT FEE. THIS FEE IS NOT COVERED BY YOUR INSURANCE PLAN AND IS YOUR RESPONSIBILITY TO PAY.

I, _____, have read and understand all of the massage policies of Mercer Wellness Chiropractic and will comply accordingly with these policies.

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY	
Name (as it appears on credit card): _____	
Credit Card #: _____	Expires: ____ / ____
Type of Credit Card: VISA MASTERCARD	3-Digit Verification # (on back of credit card): _____
Information Taken By: _____	Date: _____