

Practitioner/Clinic Name: The Back Alley Chiropractic & Massage

Contact Information: 2060 E Tangerine Rd #182, Oro Valley AZ 85755

Client Contact Information

Client Name: _____ Date: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency Contact: _____ Phone: _____
Physician/Healthcare Provider Name: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes No
Do you have a physician referral/prescription? Yes No

Massage Information

Have you ever received professional massage/bodywork before? Yes No
How recently? _____
What types of massage/bodywork do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain: _____

List the medications you currently take:

Are you wearing contacts? Yes No
Are you wearing dentures? Yes No
Are you wearing a hairpiece? Yes No
Are you pregnant? Yes No

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (if you are unsure, please ask):
Please answer honestly, as massage may not be indicated for the below conditions.

blood clots infections congestive heart failure contagious diseases pitted edema

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____

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Health History (continued)

- Current Past Varicose veins _____
- Current Past Shortness of breath, asthma _____
- Current Past Cancer _____
- Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
- Current Past Epilepsy, seizures _____
- Current Past Headaches, migraines _____
- Current Past Dizziness, ringing in the ears _____
- Current Past Digestive conditions (e.g. Crohn's, IBS) _____
- Current Past Gas, bloating, constipation _____
- Current Past Kidney disease, infection _____
- Current Past Arthritis (rheumatoid, osteoarthritis) _____
- Current Past Osteoporosis, degenerative spine/disk _____
- Current Past Scoliosis _____
- Current Past Broken bones _____
- Current Past Allergies _____
- Current Past Diabetes _____
- Current Past Endocrine/thyroid conditions _____
- Current Past Depression, anxiety _____
- Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:

Cancellation Policy

Once you have booked a massage appointment with us it means that we have reserved our therapist's time exclusively for you. We understand that unanticipated events happen occasionally in everyone's life. We value your business and strongly believe that your time is as valuable as ours. In our desire to be effective and fair to all clients and staff, massage appointments are subject to the following cancellation policy:

Late Cancellations/No-Shows: A cancellation is considered late when the appointment is cancelled less than *24 hours* before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, you will be charged a cancellation fee as outlined below.

Cancellation is free up to **24 hours** in advance. Appointments are in high demand and your advanced notice will allow another patient access to that appointment time. *New clients and/or first appointments that result in a no show or late cancellation will be charged 100% of the scheduled fee*; otherwise, for existing clients *less than 24 hours'* notice a **50%** late cancellation fee will be charged. Cancellation fee is based on the current fee schedule at the time cancellation occurs.

How to Cancel Your Appointment: If you need to cancel or reschedule your appointment time, please call us at (520) 877-2666. If necessary, you may leave a voicemail message. We will return your call as soon as possible. Cancellation by text message is available by following the instructions on your original text reminder. Cancellations by email *cannot* be accepted.

Appointment Reminders: As an added convenience, our office offers text message reminders. If you would like to sign up for this service, ask any member of our front desk to opt in. In addition to this convenience, you can easily cancel an appointment by text message by following the instructions on your original text. *Remember, a 24-hour notice is always required for any cancellations or appointment changes.*

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork practitioners 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____

Date: _____

Parent/Guardian Signature (in case of a minor): _____

Date: _____