Client Registration & Health Information

Name:_____

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

Home Phone:_____ Work Phone:_____

Age:_____ Date of Birth:_____ Female:_____ Male:_____

Occupation:_____ Employer:_____

Emergency Contact & Phone Number:_____

Approximate date of your last visit to your health care practitioner:_____

Have you ever had a massage, seated massage or reflexology treatment before?

___Massage ___Seated Massage ___Reflexology ___Other:_____

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

Current/Past			Current/Past			Current/Past		
		NECK PAIN			ANEMIA			POLIO
		HEADACHES			NERVOUSNESS			ULCERS
		DIZZINESS			BED WETTING			ARTHRITIS
		ARM PAIN			HEMORRHOIDS			CANCER
		ARM NUMBNESS			HOT FLASHES			CHEST PAIN
		HAND NUMBNESS			CONSTIPATION			DIABETES
		LOW BACKACHES			NOSE BLEEDS			DIARRHEA
		MID BACKACHES			SINUS TROUBLE			GOUT
		LEG PAIN			LUMPS IN BREAST			GOITER
		LEG NUMBNESS			SLEEPING PROBLEMS			ASTHMA
		SCIATICA			LOW BLOOD PRESSURE			COLITIS
		JOINT SWELLING			HIGH BLOOD PRESSURE			ALLERGIES
		NAUSEA			PAIN BETWEEN SHOULDERS			HEART TROUBLE
		FREQUENT URINATION			DEPRESSION			
		LOSS OF APPETITE			DIFFICULTY SWALLOWING			

Use the space below to provide additional information concerning those items check or to list any other previous surgeries, accidents, previous illnesses or any other information that might be helpful to the massage practitioner.

_____

_____

_____

I understand that this massage session is for the purposes of relaxation, stress reduction, relief from muscle pain or spasm, and/or for increasing circulation. I further understand that licensed massage practitioners do not diagnose illness or prescribe medical or pharmaceutical treatment. It has been made clear to me that reflexology and massage is not a substitute for a medical examination and it is recommended that I contact a licensed health provider for any medical or health conditions.

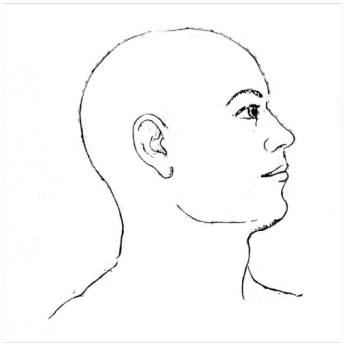
It is my choice to receive reflexology and/or massage therapy and I have provided accurate information concerning all past and current health conditions. I agree to report any changes in my health at they arise.

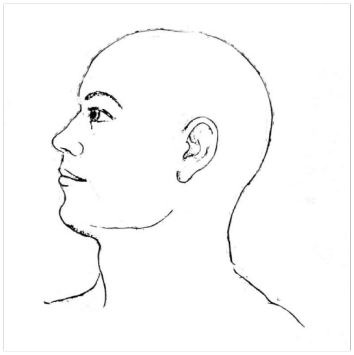
Signature: _____ Date: _____

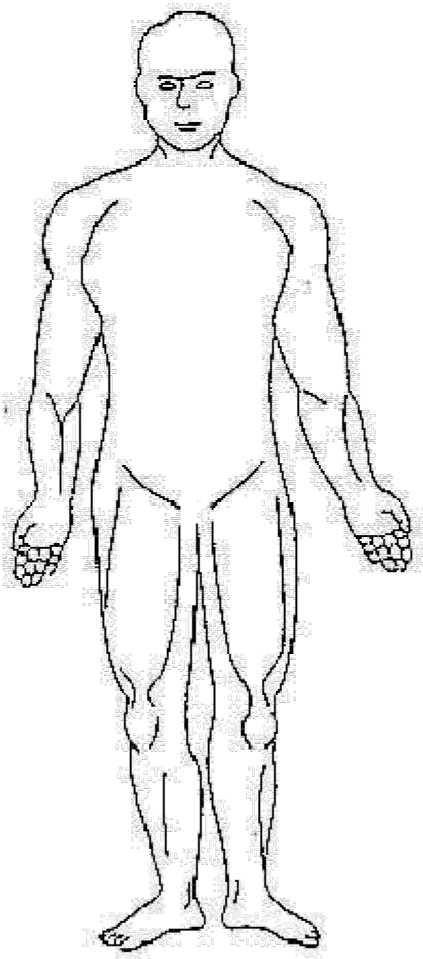
PAIN CHART

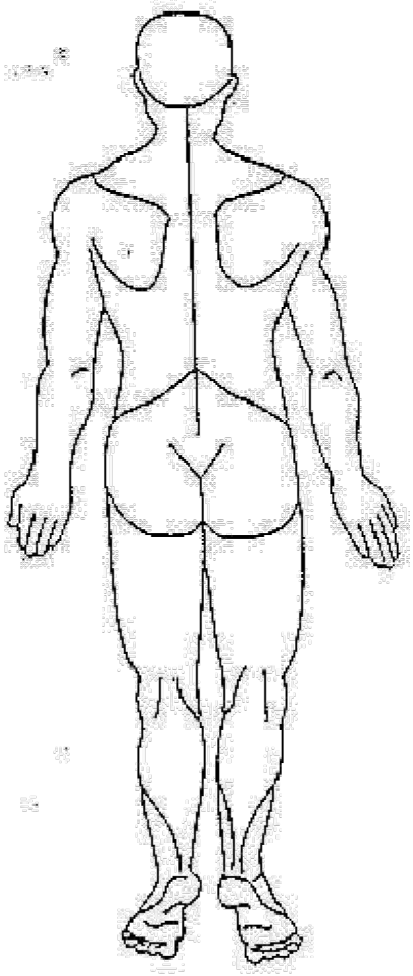
Please make the number on the drawing that most closely describes the sensations you feel.
Use arrows to show radiating pain or odd sensations. Fill this out very accurately.

1. numbness
2. tingling
3. burning
4. ache
5. sharp
6. throbbing
7. stabbing
8. pins and needles









Mindy Hayes, LMP Shannon Mojica, LMP
Chiropractic Care Center
5600 Pacific Ave SE Lacey, WA 98503

POLICY REGARDING
INSURANCE & FINANCIAL OBLIGATION

Payment is expected at the time of service. If you have insurance that covers chiropractic care, we will bill them as a service to you.

_____ NO INSURANCE. **Please be prepared to fully cover the fees for each visit by one the following way:** Cash, Check, VISA OR MasterCard.

_____ PRIVATE OR GROUP INSURANCE. **If your insurance covers chiropractic care you may still have to pay an annual deductible and/or co-pay at the time of service. We will bill your insurance for you and payment for your portion of the fees are due at the time of service and may be taken care of in one of the following ways:** Cash, Check, VISA OR MasterCard.

_____ **AUTO ACCIDENTS.** If you have PIP (Personal Injury Protection), your care is usually covered at 100%. It is our policy to bill your insurance under PIP regardless of whom was at fault. Any service or supplies not covered will become your personal responsibility. Please supply us with a claim number, billing address, telephone number, claim manager's name, attorney's name and any other information applicable.

If you do not have PIP, or you are waiting for the "at fault" party to reimburse you for medical expenses, as a service to you we will file a lien and wait for financial settlement to receive payment for our services. There is a $9.00 fee for this service to cover the cost of filing a lien.

_____ **WORKER'S COMPENSATION.** The Washington Department of Labor and Industries will pay for 100% of services and supplies once your claim has been accepted. If Labor and Industries denies your claim you will be responsible for payment of services rendered. Any services provided to you after your claim closes will also be your responsibility.

If you have already opened a claim somewhere else, please provide us with the correct claim number, date of injury, name of your claim's manager and name of the doctor you were previously seeing for this injury.

"I have read and understand the Policy Regarding Insurance and Financial Obligation."

SIGNED:_____DATE:_____

CHIROPRACTIC
CARE CENTER

Kenneth W. Trapp
DC, DACS

Travis E. Kummer
DC

360-493-2000

5600 Pacific Ave Se
Lacey, WA 98503

PATIENT CONSENT FORM

Chiropractic Care Center

Shannon Mojica LMP
Mindy Hayes LMP

Cancellation Policy

I understand that under the Chiropractic Care Center Cancellation Policy that if 24 hrs notice is not given to cancel a massage I will personally incur a $25.00 cancellation fee. This fee is to be paid upon the next visit and cannot be charged to any insurance but must be paid by the patient. If the fee has to be billed there will be an additional $5.00 processing fee.

By signing this you agree to give at least 24 hrs notice for massage appointment cancellation or risk incurring a $25.00 fee.

Print Name:_____

Signature:_____

Date:_____