NEW PATIENT REGISTRATION - MASSAGE THERAPY

Today's Date ____________

Name ____
Last First MI

Address ____
(Complete Mailing) Street Apt# City State Zip

Social Security # _________ – _______ – _________ Date of Birth______________ Age_________

Sex: ☐ M ☐ F e-mail____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered ☐ Minor

Primary Phone (______) _______ - _________ ☐ home ☐ cell ☐ work

Secondary Phone (______) _______ - _________ ☐ home ☐ cell ☐ work

Employer_________________________ Occupation__________________ Phone (______) _______ - _________

Spouse___________________________ Occupation________________ Phone (______) _______ - _________

Emergency Contact____________________Relationship _____________ Phone (______) _______ - _________

Reason for this visit: ☐ routine ☐ illness type____________ ☐other ______________________________

☐accident date _____________ type: ☐ auto ☐ home ☐ work ☐ other___________________________

Describe:____

How did you hear about us?____

PAYMENT IS EXPECTED AT TIME OF VISIT

Insurance: Primary________________________________Secondary ______________________________

In an effort to serve our patients, our office requires **24-hour Cancelation Notice** for all appointments. Cancelation fees will **NOT** be billed to insurance and are the complete responsibility of the patient. I acknowledge the above information is correct and it is my responsibility to inform RFC of any changes. I understand that I am fully responsible for any and all costs incurred for services rendered including costs not paid by my insurance company or financially responsible party and/or costs
incurred for collection on my account.

I grant RFC permission to contact me by phone/text/email for the purpose of appointment reminders. I understand my information will not be shared. Consent for Treatment, Assignment of Benefits, & Release of Information: I hereby authorize RFC to evaluate & treat me (or my dependent), release necessary information to secure payment, and I assign directly to RFC all medical insurance benefits, if any, for services rendered.

Patient's Signature:____Date:______________

If not Patient signature-circle one or fill in other: Guardian Spouse Other:______________________

Patient Condition

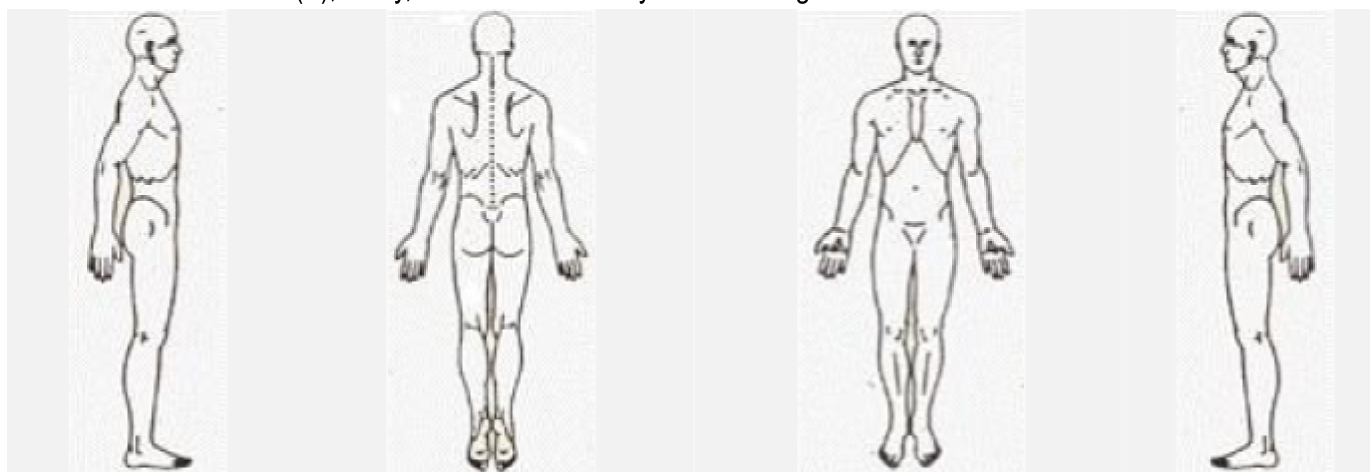
Do you have any of the following today:
☐ skin rash ☐ cold/flu ☐open cuts ☐ severe pain ☐Anything Contagious ☐ injuries/bruises

Do you have any allergies to:
☐ Medications ☐foods (nuts, etc.) ☐environmental allergens (dust, pollen, fragrances)

☐ reactions to skin care products

If any of the above are checked, please give details:

Are you wearing: ☐ contact lenses ☐ hearing aid ☐ hairpiece
Please indicate with an (X), if any, the areas in which you are feeling discomfort:



How would you rate the level of discomfort right now on a scale of 10? _______

What is the frequency of the discomfort you are feeling right now from 10% to 100%. __________

Overall, How bad is the discomfort at its worst from 1 to 10? ________

Overall, How would you rate the discomfort at its best from 1 to 10? _______

Describe the onset of the discomfort? **Circle your answer**: is it gradual (over a period of time) or is it sudden (happened out of nowhere)

When did the discomfort begin? ____

What aggravates and relieves the discomfort? **Please mark with the letter A for aggravates or R for relieves if any of the actions or activities affect you. If the action or activity doesn't aggravate or relieves your discomfort please leave it blank.**

___ Bending	____Bowling	____Carrying	____Cleaning	____Climbing
___Cooking	____Coughing	____Crawling	____Cycling	____Dressing
___Driving	____Eating	____Exercising	____Gardening	____Jumping
___Kneeling	____Lifting	____Lying Down	____Medications	____Pulling

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___Pushing	___Reaching	___Resting	___Running	___Sitting
___Sleeping	___Sliding	___Sneezing	___Standing	___Swinging
___Turning	___Twisting	___Typing	___Writing	___Working

What percentage worsens the discomfort after it is aggravated from 0% to 100%? _____________

How long would you say that the discomfort remains that way?________________________

What is the quality of the discomfort? **Please mark the line with an X if anything in the list below describes your discomfort.**

___Aching	___Anguish	___Burning	___Continuous	___Deep
___Depression	___ Despair	___Discomfort	___Dull	___Frequent
___Intense	___Intermittent	___Mild	___Moderate	___Numb
___Numbness	___Occasional	___Pain	___Random	___Severe
___Sharp	___Shooting	___Soreness	___Superficial	___Throbbing
___Tingling	___Tightness			

When is the discomfort at its worst? **In the morning, In the afternoon, In the evening, just before bed, or Other:**___________

____

What are your goals/expectations for this therapy session?

What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐None ☐Other____
Name and address of other doctor(s) who have treated you for your condition:______________________________________

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position • sighing, yawning, change in breathing stomach gurgling •emotional feelings and/or expression • movement of intestinal gas •energy shifts • falling asleep • memories

Consent Form

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:_______________________________________Date: ____________________

Witness: ___________________________________ Date: ________________________

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Massage Cancellation Policy

Missed Appointments/NO SHOWS * Late Arrivals

We will apply **a charge of $85** to your account for 1 hour massage appointments if the appointment is not kept and **24 hour notification** is NOT given prior to the appointment.

Twenty four hour notice means to call, text, or email to our office 24 hours prior to your scheduled appointment time. For Monday appointments, notice must be given before close of business at noon on the Saturday before the scheduled time.

If you cannot make the appointment and wish to give your scheduled time to a family member or friend that is an existing patient, please all the office to make those arrangements. Under this circumstance, you will not be charged for a missed appointment.

If you arrive late to your massage appointment, your appointment will be shortened. Massage therapy sessions start and end to accommodate each client's experience. We have reserved this time for you and need to honor the schedule we have set for all of our clients that day.

If you are more that 15 minutes late without contacting our front desk staff, your massage you will be considered a NO SHOW and your massage will be canceled. The missed appointment fee will be charged in this case.

PATIENT PRINTED NAME:____

PATIENT SIGNATURE:____

DATE:________________________

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Agree to Pay

Patient Name: ____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself and not between my insurance company and this clinic. I request Riverwalk Family Chiropractic to complete any usual and customary reports and forms assisting in collecting from my insurance company. I agree to pay any required co-payment and/or a percentage of services as they are rendered. I also agree to pay any and all charges that are charged to my account when no insurance is provided. I understand that I am ultimately responsible for payment in full to this clinic.

Receipt and Acknowledge of Notice of Privacy Practices

I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of Riverwalk Family Chiropractic's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Andria L. Goff D.C. at (509) 888-1099 or andiragoffdc@gmail.com.

____

Signature of Patient Date

____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient Refuses to Acknowledge Receipt:

____

Signature of Staff Member **Date**

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PATIENT HISTORY

Patient Name:____________________________ Date:____

Date of Last: Physical Exam________________ Spinal X-Ray_________________ MRI, CT-Scan, Bone Scan_________________________

Please list any of the following: Allergies?____

Medications?____

Vitamins/Herbs/Minerals?____

Place a mark on “N”=No, “Y”=Yes to indicate if **you** have had any of the following and “F”=Family if anyone in your **family** has

N	Y	F	
□	□	□	AIDS/HIV
□	□	□	Alcoholism
□	□	□	Allergies
□	□	□	Anemia
□	□	□	Appendicitis
□	□	□	Arthritis
□	□	□	Asthma
□	□	□	Backache
□	□	□	Bed wetting
□	□	□	Belching or Gas
□	□	□	Bleeding Disorders
□	□	□	Bloated Abdomen
□	□	□	Blood Clots
□	□	□	Blood in Urine □
	□	□	Breast Lump
□	□	□	Bronchitis
□	□	□	Bruise Easily
□	□	□	Bulimia
□	□	□	Cancer
□	□	□	Cataracts
□	□	□	Chemical Dependency
□	□	□	Chicken Pox
□	□	□	Colitis
□	□	□	Colon Trouble
□	□	□	Concussion
□	□	□	Constipation/Diarrhea
□	□	□	Depression/Panic Disorder
□	□	□	Diabetes
□	□	□	Difficult Digestion

N	Y	F	
□	□	□	Dizziness
□	□	□	Emphysema
□	□	□	Epilepsy
□	□	□	Excessive Hunger
□	□	□	Fibromyalgia
□	□	□	Fractures
□	□	□	Frequent Urination
□	□	□	Gallbladder Trouble
□	□	□	Glaucoma
□	□	□	Goiter
□	□	□	Gonorrhea
□	□	□	Gout
□	□	□	Heart Disease
□	□	□	Hemorrhoids
□	□	□	Hepatitis
□	□	□	Hernia
□	□	□	Herniated Disk
□	□	□	Herpes
□	□	□	High Blood Pressure
□	□	□	High Cholesterol
□	□	□	Intestinal Worms
□	□	□	Jaundice
□	□	□	Kidney Disease
□	□	□	Kidney Infection
□	□	□	Lack of Bladder Control
□	□	□	Liver Disease
□	□	□	Menopause
□	□	□	Migraine Headaches
□	□	□	Miscarriage
□	□	□	Mononucleosis
□	□	□	Multiple Sclerosis
□	□	□	Nausea
□	□	□	Nervousness
□	□	□	Neuritis

N	Y	F	
□	□	□	Osteoporosis
□	□	□	Pacemaker
□	□	□	Painful Urination
□	□	□	Painful Menstruation
□	□	□	Pain over Stomach
□	□	□	Parkinson’s Disease
□	□	□	Pinched Nerve
□	□	□	Pneumonia
□	□	□	Poor appetite
□	□	□	Liver trouble
□	□	□	Prostate Problem
□	□	□	Prosthesis
□	□	□	Psychiatric care
□	□	□	Rheumatoid Arthritis
□	□	□	Rheumatic fever
□	□	□	Scoliosis
□	□	□	STI
□	□	□	Siezures
□	□	□	Sinus Trouble
□	□	□	Stroke
□	□	□	Thyroid Problems
□	□	□	TMJ
□	□	□	Tonsilitis
□	□	□	Tuberculosis
□	□	□	Tumors Growth
□	□	□	Ulcers
□	□	□	Vaginal Infections
□	□	□	Vomiting
□	□	□	Whooping Cough
□	□	□	Other___________

Are you pregnant? □Yes □ No
Due Date__________________

Exercise	**Work Activ**
□ None	□ Sitting
□ Moderate	□ Standing
□ Daily	□ Light Lab
□ Heavy	□ Heavy La

Injuries/Surgeries you have had

Falls __________ __________ __________

Head Injuries __________ __________ __________

Broken Bones __________ __________ __________

Dislocations __________ __________ __________

Surgeries __________ __________ __________

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