WALL FAMILY CHIROPRACTIC CENTER
Dr. Michael L. Wall, D.C.
13412 Pacific Avenue
Office: (253) 531-5242 Tacoma, WA, 98444 Fax: 253-537-7293

MASSAGE THERAPY REGISTRATION FORM

Name: (First, Middle, Last) Date of Birth

Address City, State, Zip

Telephone Number Work/Cell Number

SSN E-Mail Address

Marital Status:
_____ Single
_____ Married
_____ Divorced
_____ Widowed

Sex:
_____ Female
_____ Male

Employment Status:
_____ Employed
_____ Part-Time Student
_____ Full-Time Student
_____ Other

Employment Information

Occupation Employer

Address City, State, Zip

Responsible Person or Spouse Information (If Applicable)

Name Date of Birth

Address City, State, Zip

Phone Number SSN

Relationship to Patient Occupation

Employer Employer Phone Number

Emergency Contact

Name Relationship to Patient

Phone Number Alternate Phone Number

Medical / Primary Care Physician

Name of Physician Phone Number

Approximate Address City, State, Zip

If necessary may we share our findings with your medical doctor? Yes No

How were you referred to this office?

_____ By an attorney _____ By a doctor _____ By a patient _____ Other

Please print name of source: _____

Is your injury or incident related to any of the following?

_____ Employment _____ Emergency _____ Accident _____ Auto Accident

If auto accident, please print state and date of occurrence: _____

Consent for Treatment

I voluntarily consent to receive health care service that include but do not limit examination, treatment, and diagnostic procedures.

Financial Responsibility and assignment of Benefits

I agree to pay all charges for health care services. I understand that if claims are not covered by my insurance company, I am still financially responsible for the full amount of my bill. I understand that payment is due at time of service. I further understand that returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 2% per month. I am aware that there is a **$25.00 NO SHOW FEE** or **24 hour Cancellation Policy**.

I certify that I have read this form and understand its contents.

Patients Signature (or other legally authorized person) Date

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Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? _____ Yes _____ No
How recently? _____

What are your massage or bodywork goals? _____
_____

What kind of pressure do you prefer? _____ Light _____ Medium _____ Firm

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If you answer "yes" to any of the following questions, please explain as clearly as possible.

_____ Yes _____ No Do you frequently suffer from stress?
_____ Yes _____ No Do you have diabetes?
_____ Yes _____ No Do you experience frequent headaches?
_____ Yes _____ No Are you pregnant?
_____ Yes _____ No Do you bruise easily?
_____ Yes _____ No Any broken bones in the past two years?
_____ Yes _____ No Any injuries in the past two years?
_____ Yes _____ No Do you have tension or soreness in a specific area? Please specify:_____
_____
_____ Yes _____ No Do you suffer from arthritis?
_____ Yes _____ No Are you wearing contact lenses?
_____ Yes _____ No Do you have high blood pressure?
_____ Yes _____ No Are you taking high blood pressure medication?
_____ Yes _____ No Do you suffer from epilepsy or seizures?
_____ Yes _____ No Do you suffer from joint swelling?
_____ Yes _____ No Do you have varicose veins?
_____ Yes _____ No Do you have any contagious diseases?
_____ Yes _____ No Do you have Osteoporosis?
_____ Yes _____ No Do you have allergies?
_____ Yes _____ No Do you have cardiac or circulatory problems?
_____ Yes _____ No Do you suffer from back pain?
_____ Yes _____ No Do you have numbness or stabbing pains?
_____ Yes _____ No Are you sensitive to touch or pressure in any area?
_____ Yes _____ No Have you ever had surgery? Explain below.
_____ Yes _____ No Other medical condition, or are you taking any medications I should know about?

Comments:_____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or 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.

Client Signature: _____ **Date:** _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Wall Family Chiropractic Center to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ **Date:** _____