WALL FAMILY CHIROPRACTIC CENTER
Dr. Michael 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 Cell Number Work Number

Social Security Number E-Mail Address

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Sex: _____ Female _____ Male

Employment Information

Employment Status: _____ Employed _____ Student _____ Retired

Occupation Employer

Address City, State Zip

Responsible Person or Spouse Information (If Applicable)

Name Date of Birth

Address City, State Zip

Phone Number Social Security Number

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 _____ Other

If Labor & Industries or 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/CANCELLATION POLICY. YOU MUST CANCEL BEFORE NOON THE PREVIOUS DAY TO AVOID FEE.**

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

Patient Signature (or other legally authorized person) _____ Date _____

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

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 suffer from arthritis?
__Yes __No Are you wearing contacts?
__Yes __No Do you have high blood pressure?
__Yes __No Are you taking high blood pressure medicine?
__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 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 have cardiac or circulatory problems?
__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 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. I also consent to massage therapy treatment of Gluteus Maximus, Gluteus Medius, Gluteus Minimus, Pectoralis Major, Pectoralis Minor and the Piriformis regions.

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:** _____