WASHINGTON PARK
CHIROPRACTIC
heal thrive evolve

1313 S. Clarkson St. Unit 1, Denver, CO 80210 P: 303-744-7100 F: 303-744-7109 washparkchiro.com

Massage Intake Form

Name _____ Date _____

Address _____ Date of birth_____

City _____ State _____ Zip Code _____ Gender _____

Preferred Phone _____ Email Address _____

Emergency Contact _____ Relationship _____ Phone # _____

Who may we thank for referring you to our office? _____

Employer _____ Occupation _____

Hours of computer use daily_____ Right or Left Handed_____

Hours worked each week_____ Driving?_____ On your feet?_____

Describe a typical work day _____

_____

Reason for Today's Visit

Please rank your health concerns/recent injuries and rate their severity (on a scale from 1-10, 10 being the worst)

1. _____

2. _____

3. _____

4. _____

Please list any medications you are currently taking: _____

_____

Have you had any surgeries in the past 5 years?_____

Have you ever received a professional therapeutic massage before? Y/ N

If yes, how often do you receive massages? _____

What style/pressure do you prefer? _____

What areas would you like to focus on? _____

Are there any areas you would like to avoid? _____

Are you pregnant? Y / N

Are you breastfeeding? Y / N

Health History

In the past 2 weeks have you suffered from:

Contagious Disease
❒ Flu
❒ Cold
❒ Virus
❒ COVID-19

General
❒ Cuts
❒ Abrasions
❒ Sores
❒ Bruises
❒ New Tattoo
❒ Surgery

Skin Disease
❒ Psoriasis
❒ Eczema
❒ Athlete's Foot
❒ Sunburn

In your lifetime have you suffered from:

Cardiovascular
❒ Angina
❒ Pacemaker
❒ Blood Clots
❒ Hypertension
❒ Thrombosis
❒ Phlebitis
❒ Stoke

General
❒ Inflammation
❒ Undiagnosed Lumps or Bumps
❒ Undiagnosed Pain
❒ Edema / Swelling

NEURO-PSYCHOLOGICAL
❒ Seizures
❒ Anxiety
❒ Depression
❒ Nervous/ Psychotic Conditions
❒ Epilepsy
❒ Concussion
❒ Aneurysm

Musculoskeletal
❒ Trapped or pinched nerves
❒ Varicose Veins
❒ Neuropathy

Respiratory
❒ Asthma
❒ Allergies
❒ General Sinus Issues
❒ Bronchitis

Other Medical History:
❒ Arthritis
❒ Bells Palsy
❒ HIV/AIDS
❒ Diabetes
❒ Osteoporosis
❒ Cancer If yes,
type:_____
when:_____
treatment received:
_____

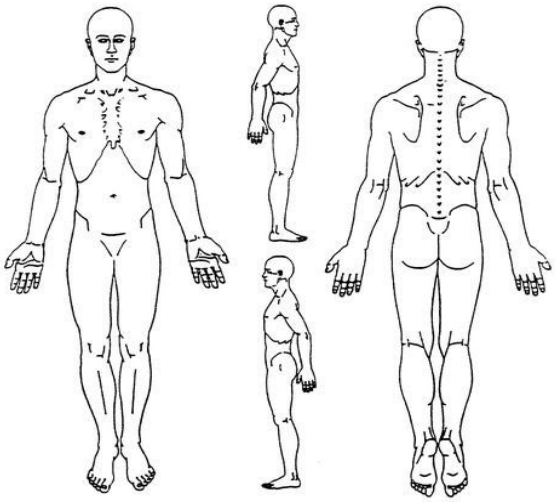
Any additional questions for the massage therapist?

_____

_____

_____

Please circle areas of discomfort:



I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X _____ _____

Signature of Patient (or parent/guardian if minor) **Date**

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FINANCIAL POLICY

Insurance:

Washington Park Chiropractic is an out-of-network provider with all health insurance companies. It is your responsibility to verify if you have benefits for out-of-network chiropractic before your first appointment. Washington Park Chiropractic can also check your benefits prior to or the day of your visit. All patient responsible payment is due at the time of service.

If you receive services from an out-of-network provider or facility or agency, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance please contact the billing department.

No-Show/Cancellation:

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible, please observe our cancellation policy for chiropractic, massage, and acupuncture appointments.

We require a minimum 24-hour notice to cancel or reschedule massage, acupuncture, and new patient chiropractic appointments. We also require at least 2 hours notice for regular chiropractic appointments.

Fees:

Chiropractic: no-shows/late cancels will be billed $25 for the first missed appointment and full price for subsequent missed appointments.

Massage/Acupuncture: no-shows/late cancels will be billed for half of the price of the appointment for the first miss and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Packages:

All packages/ pre-payments expire after 3 years. They are non-refundable. Packages may be shared between family members.

Please check the box if you agree to share your packages with family members:
▢ YES ▢ NO

_____ _____
Patient's Name (print) Date

_____
Patient's Signature