CLIENT INTAKE FORM

CONTACT ABOUT YOU

NAME			
EMAIL			
ADDRESS	**CITY**	**STATE**	**ZIP**
DATE OF BIRTH (REQUIRED)	OCCUPATION		
HOW DID YOU HEAR ABOUT US?			
MOBILE PHONE	**HOME PHONE**	WORK PHONE	
☐ OK to leave a message at the number above	☐ OK to leave a message at the number above	☐ OK to leave a message at the number above	
EMERGENCY CONTACT NAME & TELEPHONE NUMBER			

HEALTH HISTORY

MEDICAL CONDITIONS - PLEASE CHECK ALL THAT APPLY

☐ headaches	☐ neck pain	☐ back pain	☐ jaw clenching/teeth grinding
☐ leg/knee pain	☐ seizures	☐ bruise easily	☐ high blood pressure
☐ varicose veins	☐ wear contact lenses	☐ diabetes	☐ fibromyalgia
☐ active cancer (please ask for an Oncology Intake Form)	☐ numbness/tingling, if so: where?		

Please list any conditions or side-effects you have and/or medications you are taking associated with these conditions

Accidents, injuries and/or surgeries in the last two years? Please list, including date of occurrence

Are you pregnant or trying to become pregnant?
Yes☐ No☐ If yes, how many weeks:_____ due date:_____

Postpartum two years or less?
Yes☐ No☐ If yes, birth date_____

Do you have any allergies and/or skin sensitivities?
Yes☐ No☐ If yes, please List:

Our lotion products may contain nut oils. Are you allergic to nut or nut products?
Yes☐ No☐ If yes, please list the types of nuts:

Are there any additional medical issues we should know about?
If you have an issue you do not wish to state on this form, please discuss it with your therapist.

I have a Section 125 Health Savings Account (HAS), Flexible Spending Account (FSA), or Health Reimbursement Account (HRA)?
Yes☐ No☐

TERMS & CONDITIONS

LEGAL INFORMATION: BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLOWING

I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.

CLIENT BEHAVIOR

Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.

NON-SOLICITATION POLICY

I will not solicit, recruit, or encourage any person employed by this Trilogy Chiropractic for employment or the provision of services outside of the studio.

24 HOUR CANCELLATION POLICY

Should I cancel or miss an appointment with less than 24 hours notice, I authorize this Trilogy Chiropractic to charge my VISA/MC/Amex/Discover card or checking account for the full session fee.

E-MAIL POLICY

We will use your e-mail address for appointment reminders, promotions and news from Trilogy Chiropractic. Your privacy is important to us. We will not sell, rent, or give your name or address to anyone. To unsubscribe, or to recieve less or more

SIGNATURE	I acknowledge that I have received notice of HIPAA Privacy Practices or have been given the opportunity to review. _____ (Initial Here)	DATE	THERAPIST INITIALS

Trilogy Chiropractic Massage Therapy Financial Agreement (Please Initial each item)

Cancellation Policy - Massage

_____ There is a $45 fee for rescheduling/cancelling a massage if my appointments are rescheduled/cancelled within 24 hours of my massage appointment.

_____ I understand if I am late for my massage, I might not receive the entire time originally scheduled.

_____ I understand that Trilogy Chiropractic does its best to provide courtesy calls for my massage appointments, but ultimately it is my responsibility to remember my appointments. If I do not receive a reminder, I know I am still responsible for the missed appointment.

_____ I understand that these missed appointment fees cannot be billed to insurance carriers and are my financial responsibility.

Insurance Billing:

_____ I understand that the insurance quote given to me by Trilogy Chiropractic is not a guarantee of payment and that I am ultimately responsible for payment to the office for service rendered

_____ I understand that Trilogy Chiropractic bills insurance utilizing chiropractic, physical rehab, massage therapy and diagnostic imaging codes.

We require a credit card on file to use for the rescheduling or the cancellation fee: If you must reschedule or cancel we will use your credit card on the same day as your appointment to charge you for the applicable fee. We will not use your credit for anything other than the above stated reasons.

VISA/Mastercard (Circle one) Number: _____ *CCV:* _____

Expiration date: _____ *Billing Zip Code:* _____

Patient Signature: _____ Date: _____

Patient Name: _____

_____

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