MARKET PLACE CHIROPRACTIC WELLNESS CENTER
MASSAGE THERAPY HEALTH RECORD

ABOUT THE PATIENT

Name: First_____Initial____Last_____

Address:_____

City:_____

Date of Birth:_____Age:_____Gender ☐ M ☐ F

Home Phone:_____

_____

Cell Phone:_____

Cell Provider (for text reminders)_____

E-Mail Address:_____

Work Phone:_____Occupation:_____

Employer:_____

Driver's License #_____

_____

Social Security #_____

Marital Status: ☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed

Insurance Holder Date of Birth:_____

ABOUT THE SPOUSE OR PARENT

Name:_____

Cell Phone:_____

EXPERIENCE WITH MASSAGE

Have you had a massage before?

☐ No ☐ Yes

Reason for those visits:_____

_____

Previous LMP Name:_____

Approximate Date of Last Massage:_____

REFERRAL SOURCE

☐ I am a patient at Market Place Chiropractic Wellness Center referred by Dr. Clark

☐ Internet (site)_____

☐ Patient referral (name)_____

☐ Other referral source_____

_____

REASON FOR TODAY'S VISIT

What is the purpose of today's visit?_____

_____

_____

_____

How long have you had this condition?_____

Is this condition caused by an accident or injury?

☐ No ☐ Yes If Yes, please describe: _____

_____

_____

_____

Is this condition ☐ Getting better?

☐ Getting worse? ☐ Staying the same?

Have you had this condition before? ☐ Yes ☐ No

What does this condition prevent you from doing?_

_____ What were the Results?_____

_____

Other Doctors or Health Care Providers seen for this

condition:_____

Type of Treatment given:_____

_____

_____

HEALTH HISTORY

Please list ALL current symptoms or conditions:_____

_____

_____

Please list ALL current prescription or over-the-counter medications:_____

_____

Please list ALL major surgeries:_____

Do you have any Open Wounds, Rashes or Scars? Please list:_____

AUTHORIZATION FOR MASSAGE THERAPY

I hereby authorize Market Place Chiropractic Wellness Center, PLLC, Dr. Jeffrey P. Clark, or whomever he may authorize as a Licensed Massage Practitioner to work with my condition through the use of massage therapy and any necessary ancillary care as is deemed appropriate. I agree that I will not hold Market Place Chiropractic Wellness Center, PLLC, or Dr. Jeffrey P. Clark, or Licensed Massage Practitioners responsible for any pre-existing medically diagnosed condition(s) nor for any medical (non-chiropractic) diagnosis. Massage treatment records are permanent records of Dr. Jeffrey P. Clark, dba: Market Place Chiropractic Wellness Center, PLLC, and will remain on file in accordance to State Law.

Patient Signature:_____ Date:_____

(Parent or legal guardian if patient is under 18 years old. Please PRINT your name and relationship to patient in space below.)

MASSAGE CANCELLATION POLICY

I, _____

,

(Patient Name)

understand that twenty-four (24) hours notice is required to cancel a massage appointment at Market Place Chiropractic Wellness Center. Cancellation or rescheduling of my appointments can be made in person or by calling (425)335-0300.

If twenty-four (24) hours notice is not given or if I do not show up for my appointment, a $35.00 fee will be charged. This fee is my personal responsibility and cannot be billed to my insurance carrier.

I agree to pay Market Place Chiropractic Wellness Center any fees charged to me in accordance to this policy.

_____

Patient's Signature

_____

Date

_____

Witness Signature

CUSTOMER COPY

MASSAGE CANCELLATION POLICY

I, _____

,

(Patient Name)

understand that twenty-four (24) hours notice is required to cancel a massage appointment at Market Place Chiropractic Wellness Center. Cancellation or rescheduling of my appointments can be made in person or by calling (425)335-0300.

If twenty-four (24) hours notice is not given or if I do not show up for my appointment, a $35.00 fee will be charged. This fee is my personal responsibility and cannot be billed to my insurance carrier.

I agree to pay Market Place Chiropractic Wellness Center any fees charged to me in accordance to this policy.

_____

Patient's Signature

_____

Date

_____

Witness Signature