evergreen
CHIROPRACTIC & WELLNESS

Massage

Patient Information

Contact Information

Name _____ Preferred Name _____

Email address _____ Pronouns _____

Primary Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Additional Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Address _____

City _____ State _____ Zip Code _____

Sex ☐ Male ☐ Female Gender _____ Birth Date _____ / _____ / _____ Age _____

If a minor, Parent/Guardian Name(s) _____

Parent/Guardian Phone _____ Email _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow Number of Children _____

Occupation _____ Employer/School_____

Work/Student Status ☐ Full time ☐ Part time

Preferred Appointment Reminder Notification Method(s) ☐ Email ☐ Text ☐ Both

How did you hear about us? _____

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Massage Therapy Intake

Patient Name _____ Today's Date _____

Medical Information

Are you taking any medications? ☐ No ☐ Yes,_____

Are you currently pregnant? ☐ No ☐ Yes: How far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ No ☐ Yes,_____

Have you had any recent surgeries? ☐ No ☐ Yes,_____

Have you had any orthopedic injuries? ☐ No ☐ Yes,_____

Please mark any of the following that apply to you:

☐ Cancer	☐ Headaches/Migraines	☐ Arthritis
☐ Diabetes	☐ Joint Replacement(s)	☐ Neuropathy
☐ Sprains/Strains	☐ High/low Blood Pressure	☐ Fibromyalgia
☐ Stroke	☐ Heart Attack	☐ Kidney Dysfunction
☐ Blood Clots	☐ Numbness	

Explain any conditions above: _____

Massage Information

Have you ever had a professional massage? ☐ No ☐ Yes,_____

What type of massage are you wanting? ☐ Relaxation ☐ Therapeutic/Deep Tissue

☐ Other _____

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm/Deep

Do you have any allergies or sensitivities? ☐ No ☐ Yes,_____

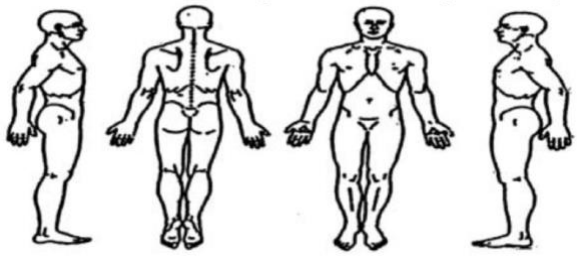
Are there any areas (feet, face, abdomen, etc) that you do not want massaged?

☐ No ☐ Yes,_____

Please mark any of the following you would like in your massage:

☐ Hot Stones	☐ Essential Oils
☐ Cupping	☐ CBD Oil

Please mark any areas of discomfort:



Anything else pertinent to your visit today? _____

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Payment Information & Agreement
Massage and Acupuncture

Patient Name _____ Date _____

Cancellation and Missed Appointment Policy

We kindly ask that you provide **at least 24 hours' notice** for any cancellation or rescheduling of massage or acupuncture appointments.

Appointments that are **missed or canceled with less than 24 hours' notice** will incur at **$50 fee.** If a **credit card is on file,** the fee will be automatically charged. If **no card is on file**, you are still responsible for the fee and **prompt payment is expected.**

This policy is in place out of respect for our therapists' time and to allow other patients the opportunity to be seen. We appreciate your understanding.

By signing below, I acknowledge that I have read and understand the above policy, and I agree to pay the $50 fee in accordance with this cancellation policy, whether or not a card is on file.

Patient Initials

Credit Card on File Authorization

Card Number _____

Expiration Date _____ Security Code _____ Zip Code _____

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

☐ **Please charge my card for any and all charges.**
I authorize automatic charges to my card on file for all services rendered.

☐ **Do not charge my card on file.**
I understand I am responsible for all balance and will pay by another method upon receiving a statement.

Patient Initials