

HANDS OF HOPE CHIROPRACTIC & WELLNESS CENTER

CLIENT INTAKE & MEDICAL HISTORY FORM

Confidential Health Record

1. CLIENT INFORMATION

Full Name:		Date of Birth:		Date:	
Address:				Referred By:	
Phone:		Email:			
Emerg. Contact:		Contact Phone:			

2. HEALTH INFORMATION

Are you taking any medications?	☐ Yes ☐ No	If yes, list:	
Any allergies? (oils, lotions, nuts, etc.)	☐ Yes ☐ No	If yes, list:	
Are you currently pregnant?	☐ Yes ☐ No	Months / Due:	
Under medical supervision / care?	☐ Yes ☐ No	If yes, describe:	

Please check [✓] any conditions that apply to you currently or historically:

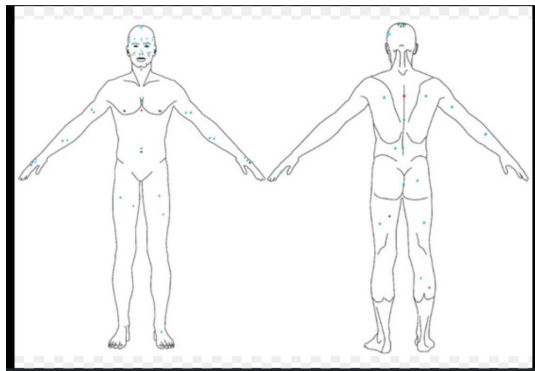
☐ Areas of swelling	☐ Decreased sensation	☐ Multiple sclerosis
☐ Asthma	☐ Diabetes	☐ Neurological condition
☐ Autoimmune condition	☐ Fibromyalgia	☐ Neuropathy
☐ Bleeding disorders	☐ Headaches	☐ Osteoarthritis
☐ Blood clots	☐ Heart condition	☐ Osteoporosis
☐ Bruise easily	☐ High / Low Blood Pressure	☐ Sciatica
☐ Bursitis	☐ HIV / AIDS	☐ Seizures
☐ Cancer	☐ Kidney disease	☐ Stroke
☐ Contagious condition	☐ TMJ	☐ Tendinitis
☐ Varicose veins	☐ Vertigo / Dizziness	☐ Other:

Areas of broken skin? (rash, wounds)	☐ Yes ☐ No	How recently?	
Previous surgeries or injuries?	☐ Yes ☐ No	Describe:	
Other health conditions / details:			

3. MESSAGE PREFERENCES & OBJECTIVES

Professional massage before?	☐ Yes ☐ No	How recently?	
Reason for seeking massage:	☐ Relaxation ☐ Specific Problem / Pain Relief ☐ Stress Reduction		
Preferred pressure:	☐ Light ☐ Medium ☐ Firm		

Target Areas (Mark or shade areas of discomfort during intake):



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge.

Client Name (Printed)	Client Signature	Date
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CONSENT, LIABILITY RELEASE & POLICIES

Confidential Health Record

4. MASSAGE THERAPY CONSENT & LIABILITY RELEASE

By signing below, you voluntarily agree to the following terms and conditions:

- **Voluntary Consent:** I voluntarily request and consent to receiving massage therapy treatments.
- **Scope of Practice:** I understand that the massage service provided is intended for general wellness, stress reduction, and muscle tension relief. Massage therapy is not a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists do not diagnose illness, disease, or medical conditions, and nothing said during the session should be interpreted as such.
- **Accurate Health History:** I confirm that I have provided an accurate and complete medical history and agree to keep my therapist informed of any new diagnoses or health changes. I confirm that I do not have any contagious diseases that could endanger my therapist or other clients.
- **Communication & Adjustments:** If I feel any pain or discomfort during the session, I will inform my therapist immediately so that pressure or techniques can be adjusted.
- **Understanding Risks:** Potential benefits, risks, contraindications, and alternatives have been explained to me. Risks include surface bruising, short-term muscle ache, or exacerbation of previously unknown injuries.
- **Liability Release:** I release the massage therapist and business from any and all liability for any harm that may occur as a result of treatment.
- **Session Termination:** I understand that either I or the massage therapist may end the session at any time.

By signing this form, I give my informed consent to proceed with massage therapy services as outlined above.

5. CANCELLATION & LATE ARRIVAL POLICY

Reservation Policy: Once you book an appointment with us, that time is reserved exclusively for you. Please review our policy regarding schedule changes and late arrivals.

- **24-Hour Cancellation Notice:** To avoid cancellation fees, please provide cancellation or rescheduling notice at least 24 hours prior to your appointment.
- **Cancellation Fee:** Cancellations or rescheduling requests made less than 24 hours before your scheduled time are subject to a fee of **50% of the service charge**. This fee will be charged to the card on file or added to your next appointment total.
- **No-Show Fee:** Failing to show up to your scheduled appointment without notice will be considered a "no show" and subject to a fee of **50% of the service charge**.
- **Late Arrival:** Due to scheduling restraints, if you are running late please call or text 540-369-3864. Time lost may be deducted from your session. Arriving more than **15 minutes late** is considered a "no show" and will require rescheduling unless discussed otherwise with your therapist.

To Cancel or Reschedule:

- **Phone / Text:** 540-369-3864
- **Email:** handsofhopechiropractic.com
- **Online:** Square Appointments Platform

I have read and fully understand the Cancellation Policy and agree to be bound by its terms. In the event of a missed appointment, I agree to pay the cancellation fee.