

ANDERSON CHIROPRACTIC MASSAGE THERAPY

If you wish to receive massage therapy in our office and bill your insurance, we must have a current case history and examination on file and you must see the doctor prior to receiving massage therapy to determine the medical necessity for the therapy.

Name: _____ Address: _____
Home Phone: _____
Work Phone: _____

Do you have any of the following conditions?

- Skin Conditions
- Allergies
- Arthritis
- Varicose Veins
- Contagious Disease
- Heart Disease
- Diabetes
- Asthma
- High Blood Pressure

Have you ever had or are you now being treated for cancer? Yes No

Have you ever had surgery?
If yes, please explain:

Are you pregnant or nursing? Yes No

Are you currently being treated by a physician for any condition?
If yes, please explain:

Are you wearing contacts? Yes No
Are you wearing dentures? Yes No
Are you taking any medications?
If yes, please list:

Approximately how much water do you drink per day? _____ 8 oz. Glasses

Do you exercise regularly? Yes No

Describe your overall level of stress:

All fees will be paid at the time of service, unless other arrangements have been made with the financial manager of Anderson Chiropractic. Any sexual remarks, suggestions, or insinuations will not be tolerated and will result in immediate termination of your massage. You will be financially responsible for the entire scheduled time, as well as escorted from the premises. By signing below you agree to these terms and conditions.

Client Name: _____ Date: _____