



BELLTOWN
Spine & Wellness

Date _____

Name: _____ Home Phone: _____ Work/Cell Phone: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: Female Male Marital Status: _____

Occupation: _____ Email Address: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Who referred you to this office? _____ Have you had massage before? _____ Last visit: _____

Bodywork Session Goals/Areas of Complaint: _____

Please circle any that apply:

- | | | | |
|----------------------|---------------------|---------------------------|-------------------------|
| Allergies | Contagious Diseases | Numbness | Stroke |
| Anemia | Diabetes | Osteoporosis | Surgery |
| Arthritis | Digestive Problems | Phlebitis | Trauma |
| Auto-Immune Disease | Epilepsy/Seizures | Radiating Pain | Temperature Sensitivity |
| Blood Clots | Headaches/Migraines | Sinus Problems | Tendonitis |
| Bursitis | Heart Condition | Skin Conditions | TMJ/Grinding Teeth |
| Cancer/Tumors | Hemophilia | Sleeping Disorder | Varicose Veins |
| Circulation Problems | High Blood Pressure | Spinal Problems/Scoliosis | Whiplash |
| Chronic Fatigue | Low Blood Pressure | Strains/Sprains | Other: _____ |
| Contact Lenses | Muscle Spasms | Stiff Joints | |

For Women: Breast Implants Menstrual Cramps PMS Pregnancy: Week _____

****Please explain any circled answers:*** _____

Surgery in the past 4 years? (Please Explain) _____

Medications? _____

- What other treatments are you receiving? Acupuncture Physical Therapy Chiropractic Naturopathic
- Water ____/day or week Alcohol ____/day or week Smoke ____/day or week
- Eat Red Meat ____/day or week Drink Caffeine: Coffee/Tea ____C/ day or week

Daily Activities: Sitting ____hrs Computer Work ____hrs On phone ____hrs Walking ____hrs

Please continue on back page.

Massage Policies

At Belltown Spine & Wellness we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have adopted the following policies:

Cancellations

- **24 hour advance notice is required** when cancelling an appointment to allow another patient to book the appointment.
- If you are unable to give us 24 hours advance notice, **you will be charged a \$35** late cancellation fee. This amount must be paid in full prior to your next treatment.
- On the other hand, if we are able to fill your time slot, **you will not be charged for that missed appointment.**

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". **You will be charged a \$35** No Show fee and future service will be denied until payment is made.

Arriving late

If you are not present for your scheduled session during the first 15 minutes (unless having telephoned us you might be late), it will be construed by us that you are a "no-show", and that time slot will automatically become available for someone else. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment, regardless of the length of the treatment actually given, **you will be responsible for the "full" session.**

If you have an open **auto injury** or **workers compensation** claim, for every 15 minutes you are late, you will be responsible to compensate the therapist \$20 to cover the time that we are unable to bill to the insurance company.

*Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.*

Patient Name: _____

Signature: _____ Date: _____

Consent for minors

- All persons 18 years old and younger must have a signed consent from a parent or guardian prior to receiving massage.
- All persons 15 years old and younger must also have a parent or guardian present in the room during the first session with a new therapist.

I _____ (parent/guardian), give permission for _____ (minor) to receive
massage therapy treatment at Belltown Spine & Wellness Center and agree to abide to the above policies.

Parent/Guardian Signature: _____ Date: _____