Limp In[1]

BALLARD HEALTH CENTER

Leap Out

AND WELLNESS SPA

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Date of Birth: _____

E-mail (for appointment reminders): _____

Phone: May we leave you messages at these numbers? If yes, please initial the boxes:

Cell (_____) _____ ☐ Work (_____) _____ ☐

Address _____ City _____ State _____ Zip _____

How were you referred? ☐ Walk/Drive by ☐ Internet Search ☐ Newspaper/Print
☐ Friend: _____ ☐ Other: _____

Is this your first massage? Yes ☐ No ☐ Occupation: _____

Reason for your visit: _____

Please list any major illnesses, surgeries, injuries, or hospitalizations in the past 5 years: _____

_____

Please check the following:

Yes No	Yes No	Yes No
☐☐ Contact Lenses	☐☐ Pregnancy How many weeks? ____	☐☐ Localized Infection
☐☐ Communicable Illness	☐☐ Acute Inflammation	☐☐ Fever

Do you now have or have you had any of the following within the past 3 years?

Yes No	Yes No	Yes No
☐☐ Heart Problems	☐☐ Thrombosis/Embolism	☐☐ Cancer
☐☐ Drug/Alcohol/Caffeine Abuse	☐☐ Ovarian/Menstrual Problems	☐☐ Constipation
☐☐ Skin Disorders	☐☐ Bursitis/Joint Disorders	☐☐ Hay Fever/Allergies
☐☐ High/Low Blood Pressure	☐☐ Phlebitis/Varicose Veins	☐☐ Chronic Illness/Pain
☐☐ Diabetes	☐☐ Respiratory Problems	☐☐ Osteoporosis
☐☐ Arthritis/Lumbago/Gout	☐☐ Sciatica	☐☐ Migraines/Headaches
☐☐ Ulcerated Colon	☐☐ Neck/Spinal Injury	☐☐ Kidney/Bladder Ailment

Insurance Information (for PIP/L&I clients ONLY)

Insurance Company: _____ Claim # _____ Date of Injury: _____

Adjuster's Name: _____ Adjuster's Phone: (_____) _____

Are you currently under the care of a healthcare professional? Yes ☐ No ☐

Name: _____ Title/Specialty: _____ Phone: (____) _____

Please list any medications taken at regular intervals: _____ Emergency Contact:

_____ Phone: (_____) _____

The above information is true and accurate to the best of my knowledge. Unless covered by a pre-arranged insurance claim, I agree to pay for my massage treatments by cash or check at the time of treatment. I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental condition. I am clear that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health. ***I understand that Ballard Health Center and Wellness Spa requires 6 hours' notice if I need to cancel my appointment. Without this notice, I may be charged a $60 late cancellation fee.***

Signature _____ Date _____

Ballard Health Center

Cancellation Policy

Effective January 1, 2019

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:

- **6 hours advance notice is required** when canceling an appointment. This allows the opportunity for someone else to schedule an appointment.

- If you are unable to give us **6 hours** advance notice you will be charged a **$60 late cancellation fee**. This amount must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their missed appointment and future service will be denied until payment is received by Ballard Health Center. Insurance and "cash" clients will be charged the $60 late cancellation fee.

Arriving late

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start treatment. Regardless of the length of the treatment actually given, **you will be financially responsible for the "full" session.**

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

We look forward to serving you.

I have read and understand the above cancellation policy:

Name (printed): _____

Signature: _____ Date: _____