

LIMP IN

BALLARD HEALTH CENTER
AND WELLNESS SPA
CONFIDENTIAL CLIENT INTAKE FORM

LEAP OUT

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 |
| <input type="checkbox"/> <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> <input type="checkbox"/> Pregnancy
How many weeks? ____ | <input type="checkbox"/> <input type="checkbox"/> Localized Infection |
| <input type="checkbox"/> <input type="checkbox"/> Communicable Illness | <input type="checkbox"/> <input type="checkbox"/> Acute Inflammation | <input type="checkbox"/> <input type="checkbox"/> Fever |

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

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

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 card, 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 24 hour notice if I need to cancel my appointment. Without this notice, I will be charged a \$60 late cancellation fee.

Signature _____ Date _____



Ballard Health Center

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms and sudden illness are just a few reasons why one might consider canceling an appointment. Arriving late, late-cancellations, and missed appointments have negative impact on our small business. To continually provide excellent service and retain a talented staff, we must ensure our entire team is compensated for every appointment. We sincerely appreciate your business and ask that you respect Ballard Health Center's policies:

- **24 hours advance notice is required** when canceling an appointment for **ANY REASON**. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us **24 hours** advance notice you will be charged a **\$60 late cancellation fee**. This fee will be charged regardless of the reason for your cancellation. We are unable to negotiate this fee and the full amount must be paid prior to your next scheduled appointment.
- **PLEASE NOTE: This policy applies to all COVID-19 related cancellations including exposure, illness, symptoms, etc.**

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for ANY 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.

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.

By signing below, I understand I have read and understand the above cancellation policy:

Name (printed): _____

Signature: _____ Date: _____