LIMP IN

BALLARD HEALTH CENTER
AND WELLNESS SPA

LEAP OUT

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 getting a 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

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 $75 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 **$75 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: ____________________