HEALTH INFORMATION FORM
NOKKEN CHIROPRACTIC CLINIC

Name _____ Date_____

Address _____
House/Apt # Street City State Zip

Physician_____
Name Clinic Phone #

Birthdate _____ Phone # (H)_____(W)_____

(C)_____ Employer/Occupation_____

Referred by _____

In case of emergency please contact:

Name: _____

Phone # (H) _____ (W)_____(C)_____

_____

CHECK ALL THAT APPLY TO YOU

__ Acne
__ AIDS (HIV)
__ Allergies
__ Arthritis
__ Athlete's Foot
__ Cancer or Tumors
__ Contact lenses
__ Diabetes
__ Eczema
__ Fractures
__ Glaucoma
__ Heart Disease
__ High Blood Pressure
__ Hives or Shingles
__ Impetigo
__ Joint/Back Problems
__ Surgical Implantations
__ Other _____
__ Kidney Disease
__ Lung Disease
__Neurological Disorder
__ Pregnancy
__ Rashes
__ Stroke
__ Thyroid Disorder
__ Varicose Veins

Are you taking medication presently? __ Yes __ No

If yes, please list the medication _____

Have you had any recent surgeries or injuries? __ Yes __ No Date of Injury: _____

If yes, please describe _____

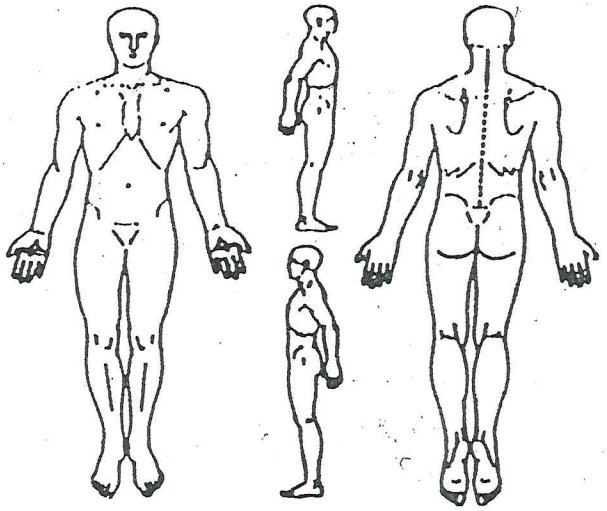
_____

Are you currently making routine visits to a physician, chiropractor, psychologist or physical therapist for an ongoing problem? __ Yes __ No

Is stress affecting your health and wellness? __ Yes __ No

If yes, please describe _____

If you are experiencing tension or pain in any area(s), please mark them on the diagrams below.



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*I (print name)_____, understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow and is non-sexual.

*The therapist reserves the right to end a session in the case of sexual innuendo or advances from client and client has the same right in instances of sexual advances or innuendo from the therapist.

*I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment of pharmaceuticals, nor do a substitute for medical examinations and or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

*Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

SIGNATURE _____Date_____

POLICIES & PROCEDURES

Welcome – I am honored that you have chosen me to be your massage therapist, and hope to make this a mutually respectful relationship. Below I have listed some information to help answer any questions you might have regarding my practice.

HEALTH

Hygiene: It is my request that all clients arrive for the massage with a clean body, free of heavy fragrances. I will do the same.

Intoxicants: I will not work on clients that have been drinking alcohol or using drugs. Massage increases the circulation of blood through the body which can intensify the effects of intoxicants, and potentially cause a dangerous situation.

Medications: Please include all the current medications that you are taking on your health form, updating it each session if necessary.

FEES & SCHEDULING

Payment: Payment for the massage will be made on that day either before or after the session (check, cash or credit card).

Fees: ½ hour - $52; 1 hour - $75; 1 ½ hour - $100 (plus MN sales tax). Gift certificates are available. When a gift certificate is used for a massage and the length of time is upgraded, an additional fee of $25 per half-hour will be charged (e.g., a ½ hour GC upgraded to a one-hour massage will be an additional $25).

Cancellation: When you made your appointment, time was reserved especially for you. If you find it necessary to reschedule or cancel your appointment, I ask that you contact Nokken Clinic 24 hours before the scheduled appointment, otherwise you will be required to pay for your appointment in full. Special consideration will be given for a late illness or emergency. I will also offer you the same courtesy of 24 hours notice if I need to reschedule your appointment, with the same consideration for late illness or emergency.

Lateness: If, for some reason, you arrive late, the massage session will end at the originally scheduled time. Full payment will be expected. If you arrive 15 minutes late to your appointment we will reschedule your session for another date. Full payment of the missed session will be required, unless you have phoned the clinic previously, and other arrangements were made.

I understand all of the stated policies and procedures.

Signature _____ **Date**_____