Arise Chiropractic Wellness Center, LLC
Dr. Lisa M. Hinkle – Dr. Angela Grove
Debbie Couture, LMT – Kathy Anderson, LMT
605 North Bentz Street, Suite 103
Frederick, MD 21701
301-662.4220

DATE: _____

NAME: _____
(FIRST) (MIDDLE) (LAST)

NICKNAME:_____
(IF DIFFERENT THAN ABOVE)

SPOUSE'S NAME: _____

EMAIL ADDRESS: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE/PGR #: _____ SEX: _____ MALE _____ FEMALE

EMPLOYER: _____

TYPE OF WORK: _____

NAME & PHONE # OF EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____

REFERRED TO THIS OFFICE BY: _____

FAMILY PHYSICAN: NAME: _____ PHONE: _____

ADDRESS: _____

NAME:_____ DATE:_____ FILE NO._____

Massage History/Treatment Information

Have you ever received a professional massage? ____Yes _____ No

If yes, frequency:_____

Date of last massage: _____

For what primary reason are you seeking massage therapy?_____

_____

Are you currently seeing a medical practitioner? ____Yes _____ No

Doctor's Name: _____

If yes, please explain:_____

May we contact this doctor? _____Yes _____ No

List regular exercise activities, including frequency: _____

Health History (Do you have or have ever had the following):

AIDS/HIV ____	Blood Clot/DVT____	Cancer/Tumor _____
Chronic Fatigue Syndrome_____	Diabetes _____	Dislocated Joint _____
Fibromyalgia Syndrome _____	Heart Disease _____	Hepatitis _____
Lupus _____	Neuropathy/Numbness _____	Stroke _____
Bruise Easily _____	Chronic Headaches/Migraines ____	Other Autoimmune Disease: _____

If you have checked off any of the above, how long ago were you diagnosed, what treatment or therapies are you currently undergoing? _____

_____

Please list all medications you are currently on: _____

_____

Please list all surgeries in your lifetime: _____

_____

Arise Chiropractic Wellness Center, LLC
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Debbie Couture, LMT
605 North Bentz Street, Suite 103
Phone 301-662-4220 ~ Fax 301-662-8195

TO OUR MASSAGE PATIENTS:

We offer four massage appointment times and fees. They are as follows:

For a 30-minute massage our fee is	$55.00
For a 45-minute massage our fee is	$65.00
For a 60-minute massage our fee is	$80.00
For a 90-minute massage our fee is	$115.00

All fees are to be paid at the time services are rendered. We accept cash, check, Visa, Master Card and Discover.

****PLEASE NOTE**** There is a 24-hour cancellation notice is required for all appointments that cannot be kept. If an appointment is missed, you will be charged the full fee of the scheduled appointment time.

If you feel that you are coming down with an illness, please take care of yourself and reschedule. You should feel better for three full days before coming in for a massage. *No matter how minor your cold or flu may seem, it can be aggravated by massage, and you may potentially spread your illness.* You will not be charged for less than 24-hour notice in these circumstances.

It is my choice to receive massage therapy. I realize that the treatment is being given for my well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination, and that it is recommended that I see a primary health care provider for diagnosis of conditions.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

I have read and understand the above terms:

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

CONSENT TO TREATMENT OF MINOR CHILD
Arise Chiropractic Wellness Center, LLC

I hereby authorize _____, LMT, to provide massage therapy to my son/daughter.

Dated this _____ day of _____ 20_____.

Signed: _____

Witness: _____