Highland, IL

1210 WASHINGTON STREET
618-654-4520

Lebanon, IL

110 W ST. LOUIS STREET
618-537-4407

General Information:

Patient Name:		**Nickname:**	
Sex: M / F		**Date of Birth:**	
Mailing Address:	**City:**	**State:**	**Zip code:**
Email Address:			
Mobile Phone #:	**Secondary Phone #:**	**Your Primary Doctor's Name:**	
Employer:		**Occupation:**	
Emergency Contact Name:	**Emergency Contact: Relationship / Phone Number :**		
How did you hear about our office?			

Massage Visit Information:

Have you received a massage before? Y / N	**Preferred Pressure: Light / Medium / Firm**
Currently pregnant or postpartum? Y / N	**Areas you do <u>NOT</u> want massaged?**

Reason for today's Massage?

_____

_____

_____

What would you like the therapist to focus on?

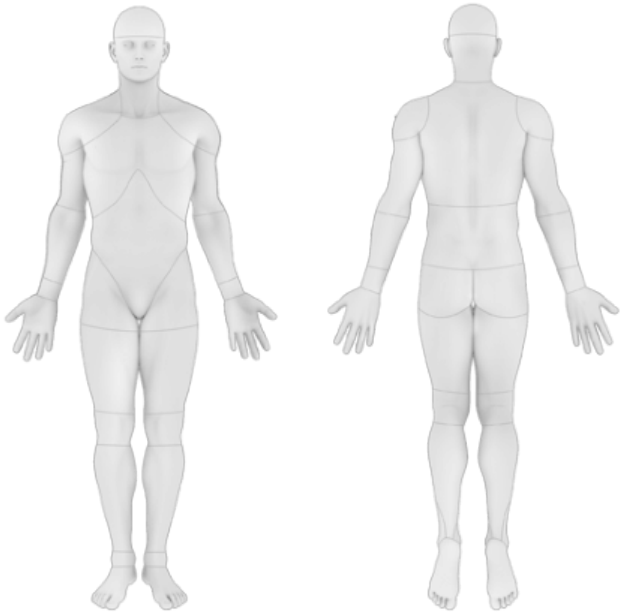
_____

_____

_____

Revised: 06/10/2026

Please mark the areas where you feel symptoms on the body diagram.



What makes your symptoms better or worse?

_____

_____

_____

Safety Screening - Circle YES or NO for Each Line

If you answer yes to anything, please explain below

Fever, illness, or feeling sick?	YES	NO
Rash, skin infection, open wound, or burn?	YES	NO
New or unexplained swelling, redness, warmth, or tenderness?	YES	NO
History of blood clots or circulation issues?	YES	NO
Currently taking blood thinners?	YES	NO
Chest pain, shortness of breath, fainting, or dizziness?	YES	NO
Experiencing a new or unusually severe headache?	YES	NO
Lymph node removal, lymphedema, history of cancer?	YES	NO
Allergy / Sensitivity to lotions, oils, fragrances, latex, or topical products?	YES	NO

Details for any YES answers / Therapist Restrictions

_____

_____

_____

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Please list any current or past medical conditions you have been diagnosed with (Examples: high blood pressure, diabetes, thyroid problems, arthritis, anxiety, EDS, etc.)

_____

_____

_____

Please list any surgery you may have had in the past with approximate dates:

_____

_____

_____

Please list any medications, vitamins, or supplements you are currently taking:

_____

_____

_____

Please list anything you may have an allergic reaction from:

_____

_____

Patient Responsibility and Scope Reminder

I understand that massage therapy at Alvarado Healthcare is provided by a licensed massage therapist and is not chiropractic care, medical diagnosis, or a substitute for care from a physician or other healthcare provider. I agree to tell my massage therapist about any medical conditions, injuries, pregnancy, medications, skin concerns, pain, discomfort, or changes in my health before or during my session. I understand that I may ask questions, request changes in pressure or technique, or stop the session at any time.

Patient Signature: _____ **Today's Date:** _____

Revised: 06/10/2026

Consent to Massage Therapy

What massage therapy may involve: hands-on soft tissue techniques, pressure, compression, stretching, movement, myofascial work, therapeutic massage, prenatal massage when appropriate, lymphatic drainage when appropriate, lotion/oil/topical products, and cupping only if selected.

Possible benefits: decreased muscle tension, relaxation, temporary pain relief, improved movement, decreased stress, and support for overall wellness. Results are not guaranteed.

Possible risks or normal responses: temporary soreness, tenderness, fatigue, redness, bruising or cupping marks, headache, dizziness, lightheadedness, skin irritation, or temporary increase in symptoms. I will tell the therapist immediately if anything feels uncomfortable.

Professional boundaries and draping: I understand appropriate draping will be used. I may ask questions, request pressure changes, decline any technique, or stop the session at any time. Massage therapy is never sexual. Inappropriate behavior may result in the session ending immediately, and I may still be responsible for the scheduled service fee.

Scope of practice: Massage therapists do not diagnose medical conditions, prescribe treatment, perform chiropractic adjustments, or replace care from a physician, chiropractor, or other medical provider.

Documentation: I understand Alvarado Healthcare may document my massage visit for continuity of care, billing, legal, and clinic purposes. Workers Comp and Personal Injury massage visits may require SOAP-style documentation.

Additional Service Consents / Screening

☐ **Cupping add-on:** I understand cupping may cause temporary circular marks, redness, discoloration, bruising, tenderness, skin irritation, or sensitivity. I have disclosed blood thinner use, clotting disorders, fragile skin, open wounds, infection, recent injury, or other concerns.

☐ **Prenatal massage:** I understand prenatal massage may require modified positioning and may be declined or stopped if safety concerns are present. I have disclosed trimester/due date, high-risk pregnancy status, blood pressure issues, swelling, provider restrictions, or pregnancy complications.

☐ **Lymphatic drainage:** I understand lymphatic drainage is gentle massage support and is not a medical diagnosis or treatment plan. I have disclosed lymphedema, lymph node removal, cancer history/treatment, active infection, fever, blood clots, heart/kidney/liver conditions, or provider restrictions.

Acknowledgment and Consent:

I have read this form or had it explained to me. I have had the opportunity to ask questions. I understand the possible benefits, risks/normal responses, alternatives, no guarantee of results, and my right to request changes, decline any technique, or stop the session at any time. I consent to receive massage therapy services at Alvarado Healthcare.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Parent/Guardian Signature, if applicable: _____ **Date:** _____

Revised: 06/10/2026

Massage Fees, Payment, and Policies

Most massage therapy services are self-pay unless Workers Comp, Personal Injury, attorney lien, or another approved claim arrangement has been accepted by Alvarado Healthcare. Insurance verification is not a guarantee of payment. I am responsible for unpaid balances, non-covered services, denied claims, and applicable cancellation/no-show fees.

Massage Service	Patient Price
30 - Minute Focused Therapeutic Massage	$60
60 - Minute Therapeutic Massage	$95
90 - Minute Therapeutic Massage	$135
60 - Minute Deep Tissue Massage	$105
90 - Minute Deep Tissue Massage	$145
60 - Minute Prenatal Massage	$100
60 - Minute Lymphatic Drainage Massage	$105
Cupping Add - On	$15

Massage Cancellation Policy

Because massage appointments are reserved specifically for each patient, Alvarado Healthcare requires at least **24 hours' notice** for cancellations or rescheduling.

- **Cancellations made more than 24 hours before the appointment:** No fee
- **Cancellations made within 24 hours of the appointment:** 50% of the scheduled service fee
- **No-call/no-show appointments:** 100% of the scheduled service fee

I understand that cancellation and no-show fees may be charged to the card on file. Emergency exceptions may be considered at the clinic's discretion.

Late Arrival Policy

I understand that if I arrive late for my massage appointment, my session may be **shortened, changed, or rescheduled** depending on the therapist's schedule and remaining appointment time.

I understand that the full scheduled service fee may still apply if I arrive late and the appointment cannot be completed as originally scheduled.

Patient Initials: _____

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Card on File Authorization

A valid card on file is **REQUIRED** to reserve massage appointments and may be securely stored through Alvarado Healthcare's payment processor.

Payment is normally collected at checkout after the completed appointment. However, I understand and authorize Alvarado Healthcare to charge the card on file if needed for an unpaid massage balance, applicable cancellation fee under the Massage Cancellation Policy , or no-call/no-show fee.

I understand that my card information is stored securely through the clinic's payment processor and is not stored directly by Alvarado Healthcare.

Patient Initials: _____

Hipaa / Privacy Acknowledgment

I understand that Alvarado Healthcare may use and disclose my health information for treatment, payment, and healthcare operations as permitted by law.

I understand that I may request access to my records, request corrections, request restrictions, request confidential communications, and receive a full copy of the Notice of Privacy Practices.

I also understand that I may ask for a full copy of any policy, consent form, or privacy notice at any time.

Patient Initials: _____

Patient Acknowledgment

By signing below, I acknowledge that I have reviewed this massage intake packet, had the opportunity to ask questions, and agree to the terms, policies, and consents described in this packet. My signature applies to this massage therapy packet.

Patient Name (Printed) : _____

Patient Signature: _____ **Date: _____**

Parent/Guardian Signature, if applicable: _____ **Date: _____**

YOU'RE FINISHED!

ALVARADO HEALTHCARE

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