LUBOVICH CHIROPRACTIC, P. A. 10880 175th Ct. W. Suite 120 · Lakeville, MN 55044 · 952-898-4900

Chart#:________________________

MASSAGE THERAPY

Last Name ______________________________ Legal First ________________________ Middle Initial_____

Sex: ___M___F Birthdate:___/___/_____ Single___ Married___ Widowed___ Divorced___ Separated___

Home Phone#:______________________________ Cell#:____

Can we leave a message? ___Y___N Email:____

Address:____
street city state zip

Emergency Contact:__________________________ Relationship:__________________ Phone#:______________

Reason for getting a massage?____

Have you ever experienced a professional massage? ____Yes ____No

Please check areas you <u>DO NOT</u> want massaged. A full body massage includes:
___head ___face ___neck ___upper chest ___back ___arms/hands ___legs/feet ___buttocks

Please circle how much pressure do you prefer: Light 1 2 3 4 5 Deep

Please check conditions you have or have had:

___TENSION OR SORENESS
___A COLD
___ECZEMA
___FLU
___FIBROMYALGIA
___HIGH BLOOD PRESSURE
___ENDOMETRIOSIS
___NAIL FUNGUS
___HEPATITIS
___OTHER HEART/CIRCULATORY PROBLEMS
___BROKEN BONES IN THE PAST 2 YEARS

___OPEN SORES OR CUTS
___CONTAGIOUS SKIN INFECTIONS
___VARICOSE VEINS
___AIDS/HIV
___ATHLETE'S FOOT
___LOW BLOOD PRESSURE
___FIBROIDS
___ANY INFECTIOUS DISEASE
___HEART ATTACK

___ALLERGIES
___THYROID PROBLEMS
___DIABETES
___BACK PAIN
___NUMBNESS/STABBING PAIN
___PLANTAR WARTS
___HERPES
___SPINAL INJURIES
___SURGERIES AND THERAPIES
___KIDNEY PROBLEMS

Do you have any other medical conditions the therapist should be aware of?

____

Have you been in an accident or suffered any injuries in the past 2 years? ____Yes ____No
If yes, please explain:____

Are you pregnant? ____Yes ____No If yes, due date:____

Do you wear contact lenses? ____Yes ____No

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Patient Name: ______________________ Chart# ______________

INFORMED CONSENT

I hereby request massage therapy services at Lubovich Chiropractic P.A. I understand, as with any health care procedures, that there are certain complications, which may arise during massage therapy treatments. I do not expect the therapist to be able to anticipate all risks and complications, and I wish to rely upon the therapist to exercise judgment during the course of the procedure(s) which the therapist feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of massage therapy. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

MY CERTIFICATION

This medical history given is accurate and complete to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile because massage/bodywork should not be performed under certain medical conditions. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Additionally, appointments not kept or cancelled with less than 24 hour advance notice will be subject to a fee of the usual cost of the service. I understand that massage is not a replacement for medical or chiropractic treatment and that the therapist is not responsible for diagnosing any injury or other medical condition.

MY PRIVACY

I have had access to a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditations.

FINANCIAL RESPONSIBILITY

I understand and agree that I am expected to pay for massage services at the date and time of appointment. **I understand that failure to show for my scheduled appointment and same day cancellation will result in a cancellation/no-show fee. I understand massage gift certificates need to be present at the time of the appointment in order to be used. Purchased and lost certificates are my responsibility and will not be reimbursed by Lubovich Chiropractic P.A.**

*PLEASE NOTE THAT AS WE ARE A CLINICAL SETTING, OUR THERAPISTS ARE NOT ABLE TO ACCEPT TIPS

Patient/Guardian Signature ____ Date ________________