Client Intake Form – Therapeutic Massage Amesbarry Chiropractic

Today's Date_____

Name_____ Date of Birth_____

Cell number: _____ Other number_____

Email_____ Occupation _____

Emergency Contact Name_____ Phone_____

Name of person who referred you for massage_____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Which type massage do you want? ____Focus on issues ____Relaxation Only ____Both

What level of pressure you would prefer: ____Light ____Medium ____Deep ____I don't know

Have you been involved in a car accident or Work Comp injury in the last 6 months? Yes No

Have you had a professional massage before? Yes No If yes, how often? _____

Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____

Would you like essential oils used during your massage? Yes No

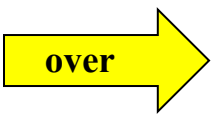
Do you have sensitive skin? Yes No

Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____

Please list specific areas of the body where you are experiencing tension, stiffness, pain or discomfort.

_____

Fill out other side



Medical History

Do you currently or have you ever had any of the following: (please check)

__ phlebitis
__deep vein thrombosis/blood clots
__ joint disorder
__artificial joint
__ osteoporosis
__ epilepsy
__ cancer
__ back/neck problems
__ Fibromyalgia
__ TMJ
__ carpal tunnel syndrome
__contagious skin condition
__tennis elbow
__recent fracture
__recent surgery
__ headaches/migraines
__sprains/strains
__ decreased sensation
__open sores or wounds
__circulatory disorder
__varicose veins
__atherosclerosis
__easy bruising
__ rheumatoid arthritis/osteoarthritis/tendonitis
__swollen glands
__current fever
__ diabetes
__heart condition
__high or low blood pressure

Are you pregnant? ____Yes ____No If yes, how many months?_____

Are you currently under medical supervision? Yes No
If yes, please explain_____

Do you see a chiropractor? Yes No If yes, how often?_____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

TREATMENT: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. **If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort.** I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

PAYMENTS, NO SHOW AND SHORT NOTICE CANCELATIONS:
I understand all payments are due the date of service, with the exception of auto insurance paying for services. I understand this is not being run through my general insurance.

If I do not show up for my appointment or call 24 hours in advance to cancel; I understand I personally have to pay a fee of $40 for 60 min. appt. $50 for 90 min appt. or $20.00 for 30 min appt. for the time that was blocked for my massage to compensate the therapist for lost pay.

Signature of client: _____ Date _____