HELWIG FAMILY CHIROPRACTIC

live well adjusted

Massage Therapy Case History Form

Date:_____

PERSONAL INFORMATION

Name: _____ ☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr.
Last First Initial

Home ph:(___)_____ Cell ph:(___)_____ Business ph: (___)_____

Email Address (for appointment reminders only): _____

How did you hear of our office?_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Birth Date: Day / Month / Year Age:_____ Sex: ☐M ☐F Height: _____ Weight: _____

Occupation:_____ Chiropractic Doctor: _____

HEALTH HISTORY

Check (√) any of the following conditions you currently have:

☐ High / Low Blood Pressure	☐ Chest Congestion	☐ Migraines
☐ Heart Problems	☐ Cancer	☐ Menstrual Problems
☐ Bleeding Disorder	☐ Contagious Disease	☐ Bruise Easily
☐ Poor Circulation	☐ HIV / AIDS	☐ Skin Condition
☐ Painful Calves	☐ Osteoporosis	☐ Digestive Problems
☐ Diabetes	☐ Arthritis	☐ Cold / Flu
☐ Epilepsy	☐ Muscle Cramps	☐ Fatigue
☐ Asthma	☐ Tingling / Numbness	☐ Pregnancy (___ Weeks)
☐ Allergies	☐ Headaches	

Medication currently taking:_____

Check (√) any of the following areas that are <u>currently</u> causing you problems:

☐ Neck	☐ Low Back	☐ Chest	☐ Legs
☐ Shoulders	☐ Arms	☐ Abdominals	☐ Feet
☐ Upper Back	☐ Hands	☐ Buttock	☐ Knees
☐ Mid Back	☐ Wrists	☐ Hips	☐ Ankles

How did these problems occur?_____

Surgeries and injuries (including dates):_____

_____

Additional or specific information about your health history:_____

_____

I certify that the above information is correct and current. I agree that it is my responsibility to ensure that the therapist is always aware of any new conditions or changes to my health.

_____ _____

Print Patient's Name **Signature of patient (or Parent/Guardian)**

_____ _____

Date Signed **Witness to Signature Above**

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FEE SCHEDULE

Please review the following fee schedule. The purpose of this agreement is to clarify your financial responsibilities so that we can devote our efforts to getting you well.

Massage Therapy

- **30 minutes: $52**
- **45 minutes: $68**
- **60 minutes: $80**
- **90 minutes: $108**

**Fees subject to change without notice*

Forms of Payment:
Full payment of all fees is due when service provided. We accept Cash, Visa, MasterCard, and Interac. **Any credit arrangements must be authorized in advance.**

Missed/Cancelled Appointments:
Your massage therapy appointment is reserved especially for you. If you are unable to keep your scheduled appointment, kindly give us **24-hour notice** to avoid being charged a cancellation fee of:

- **$20** for a 30-minute massage
- **$25** for a 45-minute massage
- **$30** for a 60-minute massage
- **$40** for a 90-minute massage

**Fees subject to change without notice*

Appointments begin promptly at the scheduled time:
Your massage appointment will begin promptly at the scheduled time. If you are late for your appointment, the massage therapist is not responsible for this lost time.

INFORMED CONSENT TO MASSAGE THERAPY

I understand that the massage I receive is provided for the purpose of basic relaxation, stress reduction, therapeutic relief of muscular tension and other healthful benefits. I further understand that massage should not be construed as a substitute for chiropractic/medical examination, diagnosis or treatment and that I should see a chiropractic doctor, medical doctor, or other qualified specialist for any other health ailment I am aware of.

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my health conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my chiropractic/medical profile and understand that there shall be no liability on the therapists part should I forget to do so.

I also understand that any illicit, sexually suggestive or inappropriate remarks made by me will result in immediate termination of the session and I will be liable for payment for the full scheduled appointment.

I hereby consent to massage therapy at this office. I intend this consent to apply to all my present and future massage therapy treatments.

Please ask if you have any questions about this agreement. By signing below, you hereby understand and agree to the above.

_____ _____

Print Patient's Name **Signature of patient (or Parent/Guardian)**

_____ _____

Date Signed **Witness to Signature Above**