# Patient Intake Form – Therapeutic Massage

**Personal Information:**

Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

Email: _____ DOB: _____

Emergency Contact: _____ Phone: _____

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

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage? _____

2. Do you have any difficulty laying on your back, front, or sides? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, ointments, or essential oils? Yes No

   If yes, please explain _____

4. What is your occupation and how many hours per week do you work?

   _____

5. Do you sit for long hours or do any repetitive movement in your work?

   Please explain _____

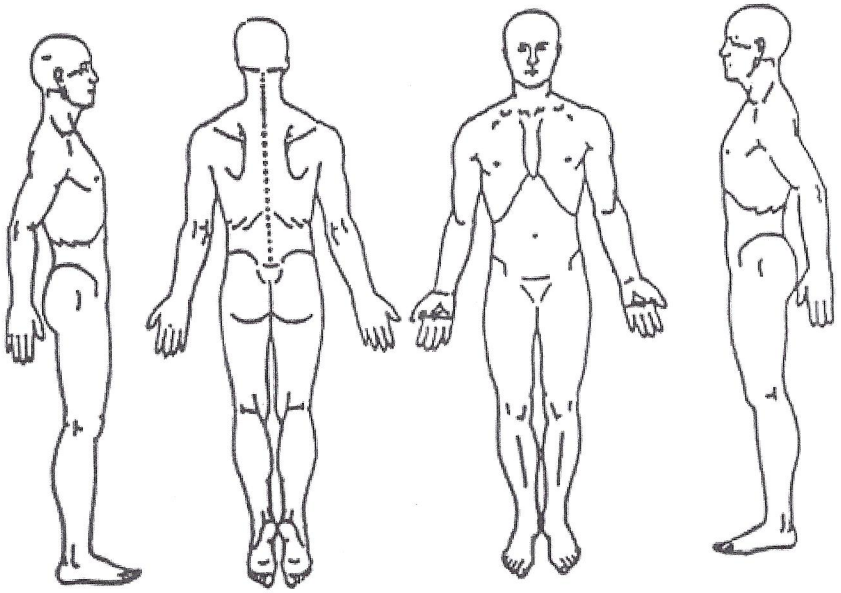
6. Do you exercise regularly? Yes No

   If yes, what kind of activities do you perform & how often _____

8. Do you have any particular goals for this massage therapy session? Yes No

   If yes, please explain _____

Please circle or shade in any areas of the body where you are experiencing tension, stiffness, pain, or other discomfort:



**Medical History:**
Please check any condition below that applies to you

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) headaches/migraines
( ) cancer
( ) swollen glands
( ) heart condition
( ) high or low blood pressure
( ) varicose veins
( ) phlebitis
( ) atherosclerosis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid
( ) arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) TMJ
( ) Fibromyalgia
( ) diabetes
( ) carpal tunnel
( ) circulatory disorder

Please explain any condition you have marked above

_____

Are there any other conditions not listed above that the massage therapist should be aware of?

_____

Are you currently taking any medications? Yes No

If yes, please list _____

Are you pregnant? Yes No

If yes, how many months? _____

Draping will be used during the session – only the area being worked on will be uncovered.

**Consent to treat:**

I, _____ (print name) 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 this session, I will immediately inform the therapist so that the pressure and/or strokes 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, chiropractor or 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 spinal or skeletal 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: _____ Date: _____

**Consent to treat a minor:**

Clients under the age of 18 must be accompanied by a parent or legal guardian unless we have obtained written consent from the parent or legal guardian.

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive therapeutic massage.

Signature: _____ Date: _____

Advanced Family
CHIROPRACTIC

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# Massage Cancellation Policy

Advanced Family Chiropractic would like to thank you for choosing us as your massage therapy provider. We want to make every effort to ensure that your experience in our office is a positive one. Due to this fact, we would like to be efficient as possible in giving you the best care available. Our staff will verify your appointment via text or phone the day before your scheduled appointment. Therefore, it is necessary for you to contact our office 24 hours prior to the day of your appointment to cancel or reschedule. If we do not receive notification 24 hours prior or if you no show your appointment, a $25.00 Late Massage Cancellation fee will be assessed and applied to your account.

Inappropriate physical and/or verbal conduct by the client toward the therapist or by the therapist toward the client is unethical, inappropriate and unacceptable. If the therapist or client's safety feels compromised, the session will be stopped immediately.

If you have any questions or concerns please ask any of our front office assistants and they would be more than happy to address your questions.

_____ _____

Patient Signature Date