CHIRO CARE
ARLINGTON

TODAY'S DATE: _____

MASSAGE INTAKE FORM

CLIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	❑ MR. ❑ MS. ❑ DR.	❑ MRS. ❑ MISS.	MARITAL STATUS (PLEASE CHECK) ❑ S ❑ M ❑ D ❑ W
HOME PHONE #: ( )	CELL PHONE #: ( )	BIRTH DATE: / /		AGE:	SEX: ❑ M ❑ F
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	EMAIL ADDRESS:	
OCCUPATION:	EMPLOYER:	WORK PHONE #: ( ) EXT.			
EMPLOYER STREET ADDRESS:	CITY:	STATE:	ZIP CODE:		
NAME OF YOUR PRIMARY CARE PHYSICIAN:	ADDRESS:	OFFICE PHONE #: ( )			

CANCELLATION POLICY

PLEASE ALLOW A 24 HOUR NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT, OTHERWISE YOU WILL BE RESPONSIBLE FOR ½ THE COST OF THE ORIGINAL APPOINTMENT SCHEDULED. _____ **(INITIAL)**

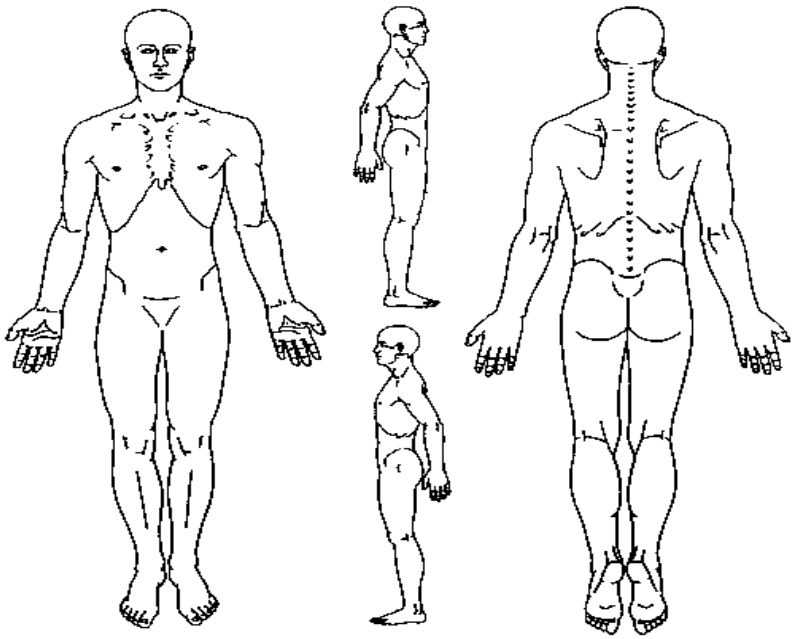
PLEASE CHECK ANY HEALTH CONDITION(S) YOU HAVE EXPERIENCED

☐ HEART DISEASE	☐ ARTHRITIS	☐ ALLERGIES	☐ CANCER
☐ DIABETES	☐ HYPERTENSION	☐ HIGH CHOLESTEROL	☐ SKIN CONDITION(S)
☐ RECENT SURGERIES	☐ CARDIOVASCULAR DISEASE	☐ OSTEOPOROSIS	☐ CURRENT FLU / INFECTION
☐ VARICOSE VEINS	☐ BLEEDING DISORDERS	☐ LOSS OF SENSATION	☐ RECENT HOSPITALIZATION
☐ OTHER:			

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE:	RELATIONSHIP TO PATIENT:	CELL / HOME PHONE #: ( )	WORK PHONE #: ( )

PLEASE MARK ANY AREA OF PAIN / DISCONFORT



– TURN OVER –

INFORMED CONSENT

THE NATURE OF MASSAGE THERAPY.

I understand that massage therapy performed by a licensed massage therapist is intended but not limited to: enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation.

I understand that massage therapy is not a substitute for medical treatment or medication, and that it is recommended that I concurrently work with my Primary Care Physician for any condition(s) I may have. I am aware that a licensed massage therapist does not diagnose illness, does not prescribe medications and that spinal manipulation are not within scope of their practices.

RECOMMENDED MASSAGE PROCEDURES.

As a part of massage you will be consenting to the following procedures which may be included as part of your treatment:

- Relaxation massage
- Sports massage
- Deep tissue massage
- Problem specific massage
- Myofascial release
- Trigger point therapy

MASSAGE THERAPY IS GENERALLY SAFE; HOWEVER, IT CAN BE DANGEROUS IN CERTAIN SITUATIONS.

- If you have a blood disorder, check with your doctor before having a massage
- If there is a clot in your vein, massage therapy can cause the clot to move, which can cause serious complications.
- If you have a cardiovascular disease, check with your doctor before having massage. Cardiovascular disease can include swollen blood vessels, blood clots, and/or heart disease.
- You should not have a massage if you have a burn, infected skin, herpes simplex / cold sores, diffuse bruising, swelling or open wounds.
- If you have severe back pain, fever or the chills you should check with your doctor before having a massage as these can be symptoms of a serious condition.
- If you have been in a recent motor vehicle or work related accident you should check with your doctor before having a massage.

OTHER TREATMENT OPTIONS.

- Rest, Chiropractic Care
- Recommendation to follow-up with primary care physician
- Referral to additional healthcare providers (i.e. physical therapy, acupuncture, etc.)

I FURTHER UNDERSTAND THAT EITHER THE CLIENT OR THE MASSAGE THERAPIST HAS THE RIGHT TO TERMINATE THE MASSAGE SESSION FOR ANY REASON AT ANY TIME.

I HAVE INFORMED THE LICENSED MASSAGE THERAPIST OF ALL MY KNOWN PHYSICAL CONDITIONS, MEDICAL CONDITIONS, AND I WILL KEEP THAT MASSAGE THERAPIST UPDATED ON ANY CHANGES TO MY HEALTH.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I CERTIFY THAT I HAVE READ THE ABOVE EXPLANATIONS REGARDING MASSAGE THERAPY, DISCUSSED IT WITH THE LICENSED MASSAGE THERAPIST AND HAVE HAD ANY QUESTIONS ANSWERED TO MY SATISFACTION. BY SIGNING BELOW AND HAVING BEEN INFORMED OF THE MATERIAL RISKS, I HAVE GIVEN MY CONSENT TO INITIATE MASSAGE THERAPY.

_____

PRINT NAME

_____ _____

SIGNATURE ***[SIGNATURE OF PARENT OR GUARDIAN]*** **DATE**

MY INITIALS, BELOW, CERTIFIES THAT I HAVE BEEN OFFERED / RECEIVED A COPY OF CHIROCARE ASSOCIATES, PC NOTICE OF PRIVACY PRACTICE.

CLIENT INITIALS: _____