MASSAGE THERAPY CLIENT INFORMATION

24 – Hour Cancellation Policy:

All cancellations and no-shows will be billed at current rates if not notified within 24 hours.
I agree to these terms and understand my account will be billed under the conditions stated.

Signature:_____ Date: _____

Personal Information

Name: _____ Telephone ( ) _____Date of Birth: _____

Address: _____ City:_____ State: _____ Zip:_____

Referred by: _____Telephone ( )_____

In Case of Emergency: _____Telephone ( ) _____

General & Medical Information

Occupation: _____ Age:_____ Circle: Male Female

Physician Name & Address: _____

What brought you in today? _____

Have you ever experienced a professional massage session? (Circle) Y N How Recently?_____

Please list any Sports or Regular activities you do: _____

Please review the following questions and circle Yes or No. If you answer "yes", please explain as clearly as possible in the lines provided.

Yes No Do you have diabetes? If so, when was your last injection today?_____

Yes No Do you experience frequent headaches?_____

Yes No Are you Pregnant? If so, please indicate how many weeks you are pregnant. _____

Yes No Do you have any allergies? Please list any _____

Yes No Have you had any broken bones in the past two years? _____

Yes No Have you been in an accident or suffered any injuries in the past two years? _____

Yes No Do you have tension or soreness in a specific area? Please specify: _____

Yes **No** Have you ever had surgery? Please outline:. _____

Yes **No** Do you have any other medical conditions or are you taking any medications I should know about? Please be specific.

_____

Please add any additional comments that you think maybe relevant: _____

_____

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage practitioners 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 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 practitioner updated as to any changed in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liability for payment of the scheduled appointment.

Client Signature: _____ **Date:** _____

Practitioner Signature: _____ **Date**: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Schmidt Chiropractic Center massage staff to administer massage, bodywork or somatic therapy techniques to my child or dependant, as they deem necessary.

Signature of Parent or Guardian _____ Date: _____

Form Updated 03/02/2009