

Massage Client Information

Name: _____ Phone: _____ Date of birth: _____

Address: _____ City: _____ Zip code: _____

Age: _____ Male Female Your occupation: _____

Referred by: _____ Date of last massage: _____

In case of emergency please call: _____

General & Medical Information

Check any of the following pains you experience:

- | | | |
|--------------------------------------------|--------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Headaches/Tension | <input type="checkbox"/> Digestive disturbance | <input type="checkbox"/> Jaw pain (TMJ) |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Pain between shoulder blades |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Arm, wrist or hand pain | <input type="checkbox"/> Ankle, Foot Pain |

Do you currently have any of the following:

- | | | |
|----------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart or circulatory disorder | <input type="checkbox"/> Skin abnormalities |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Artificial joints/limbs | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Varicose vein or artery/vein problems | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Hernias | <input type="checkbox"/> Kidney/bladder problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Inflammatory disease | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Other: _____ | |

Do you currently see a Chiropractor?	Yes	No	
Are you pregnant?	Yes	No	How far along: _____
Have you ever had back surgery?	Yes	No	If yes, where: _____
Do you have any allergies to oils/scents?	Yes	No	Explain: _____
Have you suffered any injuries?	Yes	No	Explain: _____
Are you sensitive to touch/pressure?	Yes	No	Where: _____
Do you bruise easily?	Yes	No	

Please list current medications/supplements:

Please list any medical conditions:

I understand that the massage/bodywork 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 practitioner so that the pressure may be adjusted to my level of comfort. I further understand that massage/bodywork 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 of which I am aware. 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 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Name: _____

INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of massage therapy by the therapist/technician named below or other therapists/technicians at Kraft Chiropractic Clinic. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists/technicians do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services. I accept that massage promises no long-term results nor will it cure my health problems.

The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

If at any time during the massage the client or therapist/technician is uncomfortable for any reason, they shall immediately say so.

Sexual advances of any kind will not be tolerated.

Children are not permitted in the massage room and must have childcare provided for them during the massage. Kraft Chiropractic Clinic does not provide childcare services.

Cancellation policy: A 24 hour notice is required for cancellation of your massage appointment. If 24 hour notice is not provided, you will be charged a fee of \$30.00.

All information will be kept strictly confidential and will remain with Kraft Chiropractic Clinic.

I have read and agree with all the above information. If I have any questions or concerns, I will let the therapist/technician know right away.

Signature: _____ **Date:** _____

Therapist/Technician Signature: _____