MASSAGE THERAPY INTAKE FORM

CHIROCENTRIC, LLC 12620 SW 3RD STREET, BEAVERTON, OR 97005 (503)430-7371

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Phone: _____ E-Mail: _____

Referred By: _____

GENERAL & MEDICAL INFORMATION

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session Yes/No How Recent? _____

If you answer "Yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress:

Yes No Do you have Diabetes?

Yes No Do you have frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from Arthritis?

Yes No Are you wearing contact lenses?

Yes No Do you have high blood pressure?

Yes No If yes are you taking medication?

Yes No Do you suffer from Epilepsy or Seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you suffer from Vericose Veins?

Yes No Do you have any contagious diseases?

Yes No Do you have Osteoporosis

Yes No Do you have any allergies?

Yes No Do you bruise easily?

Yes No Have you had any broken bones within the past 2 years?

Yes No Have you been in an accident or suffered any injuries in the past 2 years?

Yes No Do you have tension or soreness in specific areas? Please specify:

_____
_____
_____

Yes No Do you have any heart or circulatory Problems?

Yes No Do you suffer from back/neck pain?
Yes No Do you have numbness or stabbing pains Anywhere?
Yes No Are you sensitive to touch or pressure in any area? (Explain Below)
Yes No Have you ever had surgery?
Yes No Do you have any other medical condition Or are you taking any medications that We should know about?

Comments:

_____
_____
_____

MASSAGE THERAPY INFORMED CONSENT

CHIROCENTRIC, LLC 12620 SW 3RD STREET, BEAVERTON, OR 97005 (503)430-7371

I understand that massage therapy that 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 and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician 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 therapy 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. I also understand that any elicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date: _____

Consent to Treatment of a Minor: By signature below, I hereby authorize the Licensed Massage Therapist(s) at ChiroCentric, LLC to administer massage therapy to my child or dependent as they deem necessary.

Signature of Parent/Guardian: _____ Date: _____