Massage Client Form

Account #: ____________________

Name: ______________________________ Date: ____________

Mailing Address: ____________________________________

City: ______________________________ State: ________ Zip: ________

Phone Number: ____________________ Work Number: ____________

Email: ____________________ Sex: Male Female

Date of Birth: ____________________ Age: ____________

Occupation: ____________________ Employer: ____________

Referred by: ____________________

Marital Status: Married Divorced Single Widowed Child

Emergency Contact Name: ______________________________
Relationship: ______________________________
Emergency Contact Phone Number: ______________________________

Primary Reason for Appointment: ______________________________

Area of Complaint, Pain or Tension: ______________________________

Please Answer the Following Questions:

YES	NO	1. Females: Are you expecting? If so, how far along are you?
YES	NO	2. Have you ever had a professional massage before?
YES	NO	3. Have you ever had surgery?
YES	NO	4. Do you wear contact lenses?
YES	NO	5. Do you have skin allergies
YES	NO	6. Do you take prescription medications?
YES	NO	7. Have you suffered an acute injury recently?
YES	NO	8. Do you have varicose veins or blood clots?
YES	NO	9. Do you have arthritis
YES	NO	10. Do you have any heart problems?
YES	NO	11. Do you have blood pressure problems?
YES	NO	12. Do you have any spinal problems?
YES	NO	13. Do you exercise regularly or participate in any sports?
YES	NO	14. Do you have any other medical conditions of which I should be aware of?
YES	NO	15. Do you have any others?

MASSAGE CLIENT AGREEMENT

CAMPBELLSBURG CHIROPRACTIC

Please read carefully, and initial next to each statement, provided you have acknowledged the details listed below.

_____ I acknowledge that I am responsible to be on time for my appointment and that the therapist is not under any obligation to extend my therapy session.

_____ I agree that I am responsible to pay for the full time I have booked, with the therapist, if I am late. I understand that my appointment time is reserved for me only. If I miss an appointment or am unable to give a 24-hour notice when I need to change or cancel my appointment, I agree to pay Campbellsburg Chiropractic, in full, for the booked appointment time.

_____ It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the ancillary procedure I am about to receive could produce skin irritation, burns, stiffness, soreness, or minor complications. The probability of adverse reaction due to ancillary procedures is also considered "rare". I understand that Campbellsburg Chiropractic has provided this form as a reference and is not held liable for any services provided by the contracted massage therapist.

Tips for your massage therapist are not included in the $60 service fee and are not required but are appreciated.

____

Print Patient Name

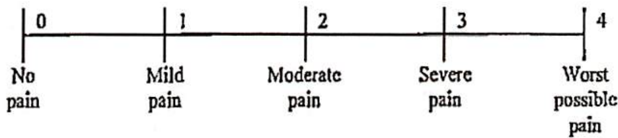
______________________________________ ______________________

Signature of Patient / Parent or Legal Guardian if under 18 Date

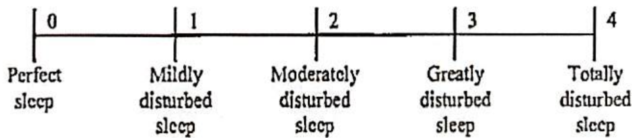
Pain Scale | Functional Rating Index

PLEASE COMPLETE THIS FORM AS IF THIS WAS YOUR WORST DAY OF PAIN WITHIN THE LAST 30 DAYS.

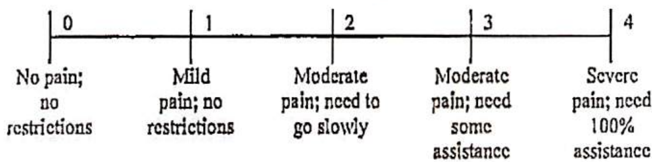
1. Pain Intensity



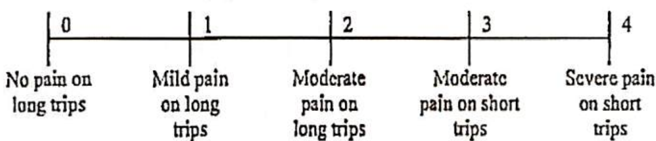
2. Sleeping



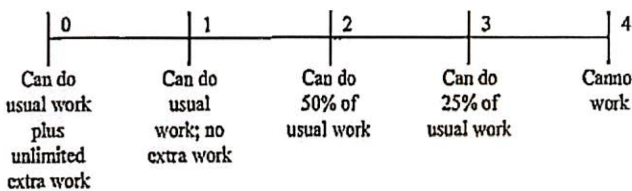
3. Personal Care (washing, dressing, etc.)



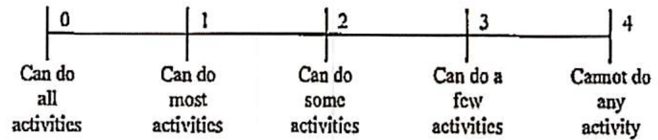
4. Travelling (driving, etc.)



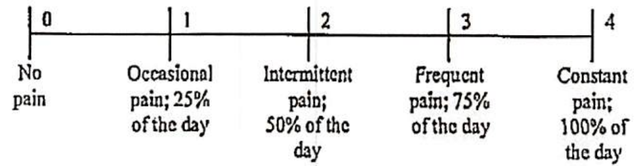
5. Work



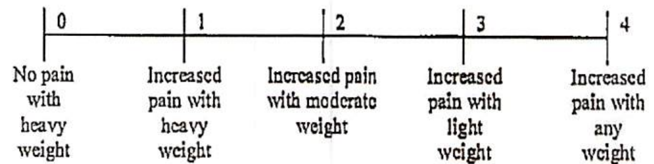
6. Recreation



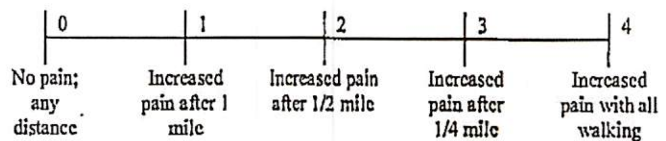
7. Frequency of Pain



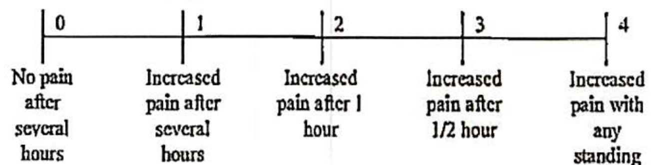
8. Lifting



9. Walking



10. Standing



____

Print Patient Name

____

Date

____

Patient Signature / Parent or Legal Guardian if under 18