Client Record - Medical History

for massage therapy services rendered by
independent massage therapists located within
the office space of Chiropractic First, PLLC

14 Stiles Rd., Suite 104 • Salem, NH 03079 • 603 894 5654

CONTACT INFORMATION

Name _____ Date _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Home phone _____ Cell Phone _____

Occupation _____ Gender: (circle one) Male Female

Work Phone _____ Email _____

In case of emergency, please contact _____ at (_____)_____

Relation to you _____

When and where is the best time to reach you? _____

Would you like a reminder call? Yes No Can I call your home to leave a reminder? Yes No

Would you like a follow-up call? Yes No Can I mail you specials and seasonal discounts? Yes No

How did you hear about me? _____ Referred by:_____

CONFIDENTIAL MEDICAL HISTORY

This information is critical to the manner in which your therapist will structure your session. 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, and if you are currently a patient of Chiropractic First, PLLC, your therapist may consult with your D.C. during the time in which you receive massage therapy services.***

Are you currently under a Physician's care? Yes No For what condition(s)? _____

_____

Do you take medication for this condition(s)? Yes No List medications you take: _____

_____

Do I have your permission to contact your Physician should the need arise? Yes No

Name of Physician _____ Phone _____

Signature to contact Physician _____ Date _____

Please circle any of the following health issues that you currently have or have had in the past year:

Allergies:_____

Anemia	Depression	Herpes Simplex	Repetitive Strain Injuries
Angina	Disc problems	Hospitalization	Sciatica
Arteriosclerosis	Dizziness	High Blood Pressure	Skin Sensitivity
Artificial/Replacement Joints	Fibromyalgia	Low Blood Pressure	Stroke
Asthma	Fungal Infections	Immune System conditions	Surgery
Blood Clots	Heart Attack	Irritable Bowel Syndrome	Surgical implants of any kind
Broken Bones	Heart Disease	Insomnia	Varicose Veins
Bruising Tendencies	(Congestive) Heart Failure	Migraines/Headaches	Whiplash
Cancer	Hemophilia	Osteoporosis	Other: _____
Carpal Tunnel Syndrome	Hernia	Phlebitis/Deep Vein Thrombosis	_____
Communicable Diseases	Hepatitis A, B , C	Pregnancy	_____

Do you have any areas of **infection**? Yes No Location/Description _____

Do you have any areas of **swelling, edema**, or **tendency to swell**? Yes No Location/Description _____

_____

Do you have any areas of **numbness** or **altered sensation**? Yes No Location/Dscription _____

_____

Do you have any areas of **pain**? Yes No Location/Description _____

Do you take any medications or drugs that alter sensation? (e.g., pain medication, muscle relaxants, alcohol or other depressants or stimulants)? Yes No List medications _____

CURRENT SPECIFIC MEDICAL CONDITIONS - please mark "YES" or "NO" for EACH condition.

CONDITION	YES	NO	PLEASE DESCRIBE
Arthritis			
Cancer or Tumors			
Cardiovascular Disease			
Diabetes			
Injuries/Accidents			
Kidney, Liver or Urinary problems			
Respiratory conditions			
Skin conditions			Circle all that apply: Acne, Abrasions/Cuts, Birthmarks/Moles, Bruises, Dermatitis, Eczema, Fungus, Herpes, Hives, Poison Ivy/Oak/Sumac, Psoriasis, Shingles, Skin tags, Sunburn, Warts, Other:
Surgery			Date of surgery: Describe:
Gastrointestinal problems			
Other medical conditions not mentioned			

IMPORTANT DISCLOSURE & SIGNATURE

Because massage and bodywork 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 massage therapist updated as to any changes in my medical profile and understand that there will be no liability on the massage therapist's part should I fail to do so. ***I also understand that if I am currently a patient of Chiropractic First, PLLC, my therapist may consult with my D.C. during the time in which I receive massage therapy services.***

Client Signature _____ Date _____

Consent to treatment of Minor: By my signature below, I authorize the administration of massage therapy to my child or dependent as deemed necessary.

Signature of Parent/Guardian _____ Date _____

Client Record - Massage Therapy

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Please print clearly and complete both sides of this form. This information is critical to the manner in which your therapist will structure your session. All information disclosed will be kept confidential.

Name _____ Date _____

MASSAGE INFORMATION

Have you ever had a professional massage before? Yes Many Times No If yes, how recent?_____

What is the amount of tension in your life? 0 1 2 3 4 5 6 7 8 9 10

(none) (average) (extreme)

What physical activities do you do on a daily basis? _____

_____

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

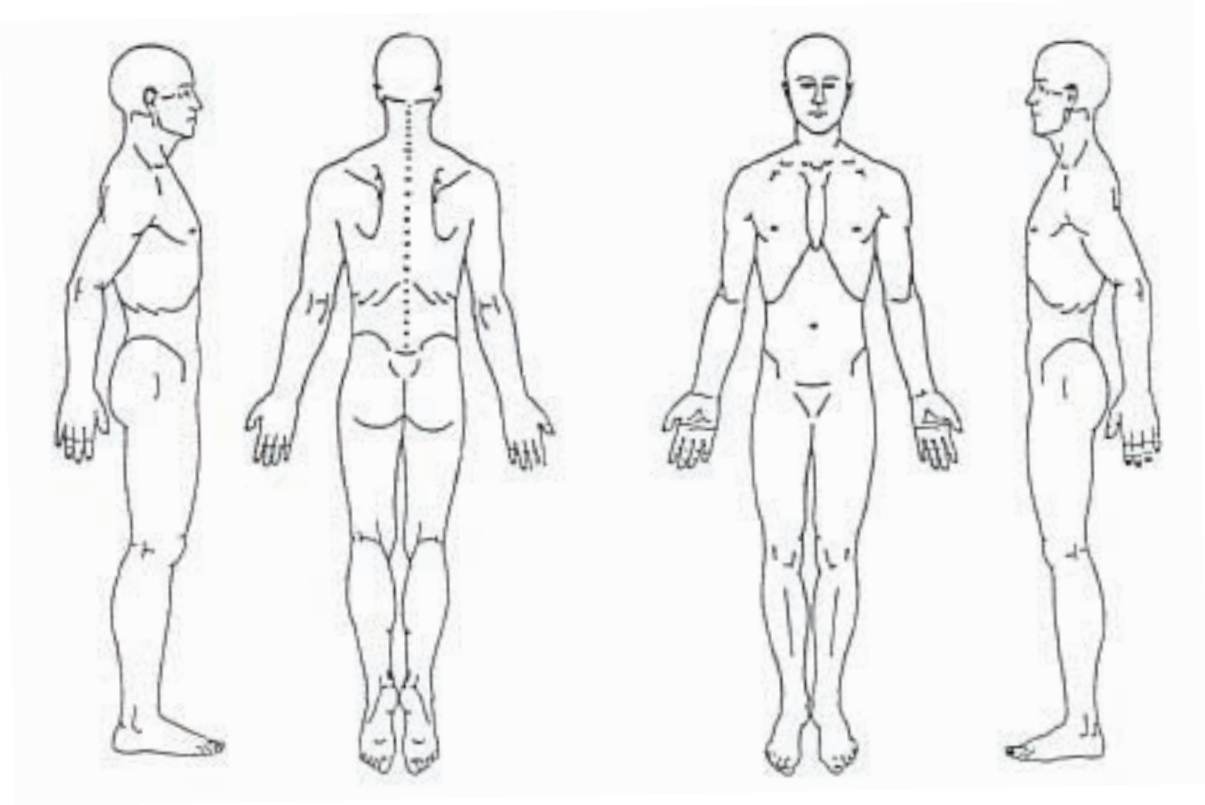
Head/Face	Shoulders	Mid-back	Abdomen	Other: _____
Neck	Arms/Hands	Low-back	Legs/Feet	_____

Do you have any discomfort lying on your back, stomach or either side? Yes No If so, please explain: _____

_____

_____

Please indicate areas where there is pain or discomfort.



Client Record - Massage Therapy

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MASSAGE THERAPY POLICIES

Please read the following policies and initial on line below.

PROPER HYGIENE IS REQUIRED OF BOTH CLIENT AND THERAPIST.

- A medical history will be completed during the first session.
- Client will be fully draped during the session.
- Appointments begin and end on time.
- Good communication between client and therapist is necessary to evaluate treatment effectiveness.
- Payment is due at the close of each session.
- Tipping is at the discretion of the client.
- **SEE SEPARATE SHEET FOR CANCELLATION POLICY.**

I have read and understand the Massage Therapy Policies. Please initial here: _____

MASSAGE THERAPY INFORMED CONSENT

I, _____ (client), understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive, non sexual experience of touch.

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I currently work with my Primary Caregiver for any conditions I may have.

Certain medical conditions are contraindications for massage therapy. I have informed the Massage Therapist of all my known physical or medical conditions, past or present, and any medication that I am currently taking so that the Massage Therapist can explain any possible contraindications. ***I will keep the Massage Therapist updated on any changes in my health status.***

I am aware that the Massage Therapist does not diagnose illness or disease and does not prescribe any course of treatment for such conditions. Any information communicated will not be construed as such. I understand that Massage Therapists do not perform spinal manipulations.

I understand that sexual harassment will not be tolerated. If sexually explicit remarks are made or sexual favors are requested or implied, the Massage Therapist will immediately terminate the session. I understand that if the session is terminated for these reasons, that I will be responsible for the full session fee and will be asked not to return for further treatments.

If I experience any physical or emotional pain or discomfort during any session, I will immediately inform the Massage Therapist so that the pressure of the strokes and/or the modalities used may be adjusted to my level of comfort. I also understand that it is within my rights as a client to terminate the session at any point if I so choose.

By signing below, I understand and agree to the above statements.

Client Signature_____ Date _____

Client Cancellation Policy

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Massage Therapists make their living by offering their time, therapeutic skills and healing touch as you are in need. ***Appointments are time slots reserved for you so that no other services are scheduled.*** If you must cancel your appointment it is very important to give a full 24-hr notice so that the time that was set aside for you can then be allotted to another in need, and the therapist can continue to make a living.

We thank you for your consideration and understanding concerning this matter.

MISSED APPOINTMENT

I understand that if I fail to arrive for an appointment without a 24-hr cancellation notice that session is considered missed, and I will pay the full amount for the missed appointment. I understand that any gift certificate associated with my appointment will count as services rendered.

LATE START

I understand that to get the most from my session, and to be fair to the therapist and other clients, sessions start and end on time. I understand that if I am late, this may result in a shortened session, in which I will still pay the full amount.

CANCELLATIONS

I understand that there is a 24-hr cancellation policy and that when I cancel with at least a 24-hr notice I will incur NO CHARGE. I understand that if I cancel within less than 24 hours and my appointment time can be re-filled, I will incur no charge, however, if my appointment time is not able to be re-filled, I will pay the full amount.

We are aware that emergencies, bad weather and illnesses happen. Cancellations due to those instances cannot be helped. In those circumstances, there will be no charge incurred for missed appointments. We simply ask that you try to call as soon as you know you will not be able to make your appointment.

I have read and understand the above policies.

PRINT NAME BELOW	SIGN INITIALS BELOW	DATE BELOW
_____	_____	_____
(Printed Name)	(Signed Initials)	(Date)