MASSAGE INFORMED CONSENT FORM

FIRST NAME:_____ **MIDDLE**:_____ **LAST:**_____

BIRTH DATE: _____/_____/_____ **PATIENT'S GENDER**: M☐ F☐ **REFERRED BY:**_____

☐ **HOME PHONE**:_____ **EMAIL ADDRESS**:_____

☐ **CELL PHONE**:_____ **SERVICE PROVIDER:**_____ ☐ Check if you would like text messages

STREET:_____ **CITY**:_____ **STATE:**_____ **ZIP CODE:** _____

1. Have you had previous massage? ☐Yes ☐No **Results**: ☐Excellent ☐Good ☐Fair ☐Poor
2. What is your goal/concern for today's session? _____
3. What kind of pressure do you prefer? ☐Light ☐Medium ☐Firm
4. Are you sensitive to touch or pressure in any area? ☐Yes ☐No Explain:_____
5. Do you experience any difficulty lying either on your front or your back? ☐Yes Front ☐Yes Back
6. Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension?_____
7. Surgery / fractures: ☐No ☐Yes Explain:_____
8. Are you under medical care or supervision now? ☐No ☐Yes If yes, for what condition:_____
9. Are you currently taking any medication? ☐No ☐Yes Explain:_____

   _____
10. Do you have numbness or stabbing pains? ☐No ☐Yes Explain:_____
11. Do you currently have cancer? ☐No ☐Yes Explain:_____ Lymph nodes removed? ☐No ☐Yes

MEDICAL HISTORY: Please check all that apply.

☐Contagious Disease(s)	☐Easy Bruising	☐Diabetes	☐Parkinson's	☐Allergies:_____
☐Pregnant (_____ weeks)	☐Headaches	☐Neck Pain	☐Whiplash	☐Back Pain
☐Multiple Sclerosis	☐Jaw Pain	☐Herniated Disc	☐Shoulder Pain	☐Elbow/ Arm Pain
☐Wrist Pain	☐Hand Pain	☐Leg Pain	☐Knee Pain	☐Ankle/Foot Pain
☐Alcohol/Drug Dependence	☐Joint Pain/Stiffness	☐Arthritis	☐Fibrosis	☐Epilepsy
☐Auto Immune Disease	☐Osteoporosis	☐Osteoarthritis	☐Asthma	☐Chronic Sinusitis
☐High Blood Pressure	☐Low Blood Pressure	☐Heart Problems	☐Heart Attack	☐Stroke
☐Blood Clots	☐Varicose Veins	☐Kidney Disorder	☐Bladder Infection	☐Loss of Bladder Control
☐Abdominal Pain	☐Hepatitis	☐Fibromyalgia	☐Dizziness	☐Past Cancer:_____
☐Smoking/Tobacco Use	☐Bad Circulation	☐Rash	☐Other Conditions:_____	

_____

Please read and initial before each statement.

_____ I understand that massage therapy given here is for the purpose of stress reduction, relief from muscle tension or spasm, or for increasing circulation and energy flow. If at any time I feel discomfort, **I will** inform my massage therapist.

_____ I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment of pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any ailments that I have.

_____ I understand and agree that I am receiving massage therapy entirely at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I HEREBY HOLD HARMLESS AND INDEMNIFY Prairielands Chiropractic Clinic, P.C., their principals, therapists, and agents from all claims and liability whatsoever.

_____ I have stated all my known medical conditions and will keep the massage therapist updated on my physical health.

_____ The massage given here is therapeutic. Any attempt to sexualize the relationship will not be tolerated, and is grounds for termination of the massage and I will be liable for payment of the scheduled appointment.

_____ Cancellations and/or rescheduling must be made **no less than 4 hours** (medical emergencies excluded) prior to the session **or full payment is expected and will be billed.** If late, our session will still end at the appointed time.

Client Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Prairielands Chiropractic Clinic's licensed massage therapists to administer massage and bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____