Integrative Health and Rehabilitation

Chiropractic Wellness Center
It's more than feeling better... it's being healthier.

Massage Therapy Welcome Packet

Patient Information

Name: _____
Last First MI Prefer to be called

Phone: _____ Email address: _____
Cell Work

Mailing Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

How would you like to receive appointment reminders? ☐ Phone ☐ Email ☐ Text

If choosing "Text" please tell us you Phone Provider (Verizon, AT&T, etc.): _____

May we send you our e-newsletter to inform you of special offers and health information? ☐ Yes ☐ No

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____ Phone: _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Reason For Your Visit

Please explain what happened: _____

When did this begin? _____ Is this interfering with: ☐ Work ☐ Sleep ☐ Daily routine

Is your condition getting: ☐ Better ☐ Worse ☐ Same Please explain: _____

Have you had this or similar conditions before, if so, please explain: _____

Have you received treatment for this condition any where else? ☐ Yes ☐ No If yes, where?_____

Health History

Have you had massage before? ☐ Yes ☐ No If yes, where? _____

Do you have difficulty lying on your front, back, or side? ☐ Yes ☐ No If yes, please explain: _____

Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No If yes, please explain: _____

Do you have sensitive skin? ☐ Yes ☐ No If yes, please explain: _____

Are you wearing: ☐ contact lenses ☐ dentures ☐ a hearing aid?

Are you currently under medical supervision? ☐ Yes ☐ No If yes, with whom_____

Are you taking any medications? ☐ Yes ☐ No If yes, please list: _____

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Do you have or ever had any of the following diseases or conditions?

☐ Severe/Frequent Headaches	☐ Heart Surgery	☐ Difficulty Breathing	☐ Frequent Neck Pain	☐ Cancer
☐ Sinus Problems	☐ Pacemaker	☐ Artificial Valves	☐ Emphysema	☐ Stroke
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Ulcers/Colitis	☐ Arthritis	☐ Asthma
☐ HIV+/AIDS	☐ Shingles	☐ Lower Back Problems	☐ Artificial Bones/Joints	
☐ Chemotherapy	☐ Diabetes	☐ Psychiatric Problems	☐ Fainting/Seizures/Epilepsy	
☐ Hi/Lo Blood Pressure	☐ Glaucoma	☐ Hepatitis	☐ _____	

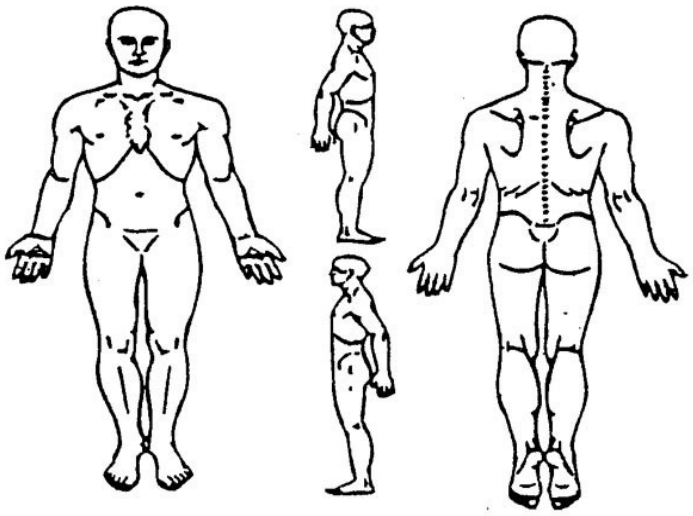
Pain Chart

What is your current weight: _____ lbs., and height: _____ ft. _____ in.

Rate your pain on a scale of 1-10 (1 being *little to no pain* and 10 being *extremely painful)*

1 2 3 4 5 6 7 8 9 10

Mark the figure below with: **Muscle Spasm = S, Burning = B, Ache = A, Numbness = N, Pins & Needles = P**



Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (*print name*) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that if I fail to attend a scheduled appointment <u>or</u> fail to provide <u>24 hours</u> notice to change my scheduled appointment I be charged the FULL AMOUNT owed for my massage.

_____
Patient Initials

Name: _____ **Date:** _____
(printed)

Signature: _____ **Witness:** _____
Adult Patient, Parent/Guardian, or Spouse