MOVEMENT CLINIC Chiropractic Sports Medicine Rehabilitation

# Massage Therapy Client Information

**Date**: _____

## Personal Information

Client's Full Name: _____

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

Home Phone: _____ Cell Phone: _____ E-mail: _____

Date of Birth: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Spouse's Name: _____

Number of Children/Ages: _____

☐ Full Time Employed ☐ Part Time Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed

Occupation: _____ Employer/School: _____

Emergency Contact Name: _____ Phone: _____

Physician's Name: _____ Referred by: _____

## Massage Experience

Have you had a professional massage before? ❑ Yes ❑ No

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are you goals for treatment? _____

## Current Health

Reason for initial consultation? _____

Do you exercise regularly and/or participate in any sports? ❑ Yes ❑ No

_____

Do you perform any repetitive movement in your work, sports, or hobby? ❑ Yes ❑ No

_____

Do you sit for long periods of time at a workstation, computer, or driving? ❑ Yes ❑ No

_____

Do you experience stress in your work, family, or other aspect of your life? ❑ Yes ❑ No

Are you experiencing stiffness, discomfort, or pain? ❑ Yes ❑ No

Have you recently had an injury, surgery, or areas of inflammation? ❑ Yes ❑ No

Do you have sensitive skin? ❑ Yes ❑ No

Do you have any allergies to oils, lotions, or ointments? ❑ Yes ❑ No

List any medications you are currently taking: _____

List any known allergies: _____

## Health History

### Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis/bursitis
- ☐ Arthritis
- ☐ Gout
- ☐ Jaw pain
- ☐ Lupus
- ☐ Spinal problems
- ☐ Migraines
- ☐ Headaches
- ☐ Osteoporosis

### Circulatory

- ☐ Heart condition
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High/low blood pressure
- ☐ Lymphedema
- ☐ Thrombosis/embolism

### Respiratory

- ☐ Breathing difficulty
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus problems

### Nervous System

- ☐ Shingles
- ☐ Numbness/tingling
- ☐ Sciatica
- ☐ Chronic pain
- ☐ Paralysis
- ☐ Multiple sclerosis
- ☐ Parkinson's disease

### Reproductive

- ☐ Pregnant
- ☐ Ovarian/menstrual
- ☐ Prostate

### Skin

- ☐ Rashes
- ☐ Cosmetic surgery
- ☐ Athlete's foot
- ☐ Herpes/cold sores

### Digestive

- ☐ Irritable bowel syndrome
- ☐ Bladder/kidney ailment
- ☐ Colitis
- ☐ Chron's disease
- ☐ Ulcers

### Psychological

- ☐ Anxiety/stress syndrome
- ☐ Depression
- ☐ Other: _____

### Other

- ☐ Cancer
- ☐ Diabetes
- ☐ Tobacco use
- ☐ Contact lenses
- ☐ Dentures
- ☐ Hearing aid

### Any other medical conditions not listed:

_____

_____

_____

_____

_____

_____

_____

## Informed Consent

I, the undersigned, have chosen to consult with and hereby give consent and request massage therapy treatment and other massage procedures to be provided by the massage therapist.

I have provided a detailed medical history and have stated all my known physical conditions and medications, and I will keep the massage therapist updated of any changes.

I understand that massage may provide benefits for certain conditions, but results are not guaranteed.

These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions, pain reduction, and provision of general wellbeing.

I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the treatment which the massage therapist feels at the time, based upon the facts then known, and is in my best interests.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

I understand that I will always be draped, and the areas undraped will be secure to ensure there is no indecent exposure. If undraping my gluteals is significant in the treatment, I do understand that it is part of the therapy.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs.

I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be altered accordingly.

I have the right to refuse, modify, or terminate services at any point, regardless of my prior consent.

I also understand the therapist also has the right to terminate a massage therapy session or refuse to treat any person or part of the body.

I, the undersigned, have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures for myself or my dependent. I intend this consent form to cover the entire course of the treatment for the present condition and for any future condition(s) for which I or my dependent seek treatment.

_____

Client Name

_____ _____

Client or Legal Guardian Signature Date

_____ _____

Massage Therapist Signature Date

## Privacy Policy

This clinic is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected. Information kept on file will not be released to a third party without the express written consent of the client, unless required for immediate medical treatment, or as required by law.

Client Initial: _____

## Appointment Cancellation Policy

There is a 1-hour cancellation and no-show policy. Clients must notify the clinic more than 1-hour prior to cancelling an appointment. Failure to do so will result in the full expected fee for that session to be billed to the client.

Client Initial: _____

## Payment Policy

Payment is due at the time of service or when purchasing a pre-paid package. ***A check made payable to Fitness and Massage, LLC or Rachel Knepp and/or a credit or debit card are the only accepted form of payment***. Pre-paid packages are non-refundable and are to be used within the calendar year of purchase. Any unused massages within a package are considered null and void. Our clinic will not bill a 3rd party payor, however, you can be provided with a receipt that can be submitted as a claim on your own. Lastly, we will also not provide any clinical documentation or other required services to any 3rd party payor for reimbursement purposes. We will provide them to you for your benefit or use as requested.

Client Initial: _____

## Fee Schedule

| | | |
|---|---|---|
| ☐ | 15-minute session | $ 30 |
| ☐ | 30-minute session | $ 60 |
| ☐ | (3) 15-minute sessions | $ 75 |
| ☐ | (3) 30-minute sessions | $ 150 |
| ☐ | (6) 15-minute sessions | $ 150 |
| ☐ | (6) 30-minute sessions | $ 300 |

Client Initial: _____ Date of Purchase: _____