Please indicate any conditions that apply to you:

☐ Bruises easily	☐ Allergies/Sensitivities, explain:
☐ Deep vein thrombosis/ Blood clots	☐ Pregnancy, how many months (please fill out pregnancy section on the back):
☐ Osteoporosis	
☐ Artificial joint	

Have you had a massage before? YES NO

Preferred massage pressure: LIGHT MEDIUM FIRM NOT SURE

Please list any health history information that you think would be useful for your massage therapist to know:

_____

_____

_____

Cancellation Policy:

At Jones Family Chiropractic, we value your time as well as our therapists. In order to provide the best service to all our clients, we have implemented the following cancellation policy.

- We kindly request that you provide a minimum of 24 hours notice if you need to cancel or reschedule your appointment. If you fail to cancel within this timeframe or attend your appointment, a fee equivalent to 50% of the cost of the massage appointment will be charged to the credit card on file for your appointment reservation. This fee compensates for the time reserved exclusively for you, which could have been allocated to another client in need of services.
- The cancellation fee must be paid in full prior to your next scheduled appointment to avoid a disruption in service. Unresolved cancellation fees may result in the inability to schedule services in the clinic.
- We do understand that emergency and special circumstances arise that are unavoidable. Please contact the clinic as soon as possible to discuss your situation and we may consider waiving any fees at the discretion of the clinic.

Initial:_____

Disclaimer

I, _____ (PRINT NAME) UNDERSTAND THAT THE MASSAGE I RECEIVE IS PROVIDED FOR THE BASIC PURPOSE OF RELAXATION AND RELIEF OF MUSCULAR TENSION. I WILL BE EXPECTED TO MAINTAIN COMMUNICATION WITH THE MASSAGE THERAPIST DURING THE MASSAGE REGARDING THE LEVEL OF PRESSURE USED SO THAT IT 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 PHYSICAL OR MENTAL MEDICAL CONDITIONS. I AFFIRM THAT I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS CORRECTLY & HONESTLY. I AGREE TO KEEP THE THERAPIST UPDATED AS TO ANY CHANGES IN MY MEDICAL PROFILE. I UNDERSTAND THAT THERE SHOULD BE NO LIABILITY ON THE THERAPIST'S PART OR JONES FAMILY CHIROPRACTIC SHOULD I FAIL TO ADHERE TO THESE STIPULATIONS.

Initial:_____

Please fill out this section if you are pregnant:

Estimated due date:_____ Weeks pregnant: _____

Medical provider's Name: _____

Medical provider's Contact Number: _____

Pregnancy History:

- Have you had any complications during this pregnancy? If yes, please provide details:

_____
_____

- Have you experienced any complications with previous pregnancies and/or do you have a history of more than 3 lost pregnancies? If yes, please provide details:

_____
_____

- Are you currently experiencing any pain, discomfort, or specific concerns related to your pregnancy? If yes, please describe:

_____
_____

- Please include any changes to your health that have occurred since becoming pregnant:

_____
_____

Pregnancy massage should always be administered in a relaxing manner. The primary goal of treatment is to provide temporary relief for aches and pains experienced during pregnancy. The pressure you have received during other massage may not be appropriate during prenatal and postnatal massages. Please let your therapist know if you are experiencing any discomfort (Ex: nausea) as in many cases issues are easily resolved.

Initial:_____

Consent to Cupping Therapy:

I _____, consent to the use of silicone cups during my massage therapy sessions. I understand that there is a possibility of tissue discolouration associated with this type of therapy that may last for a duration ranging from hours to days following treatment. I understand that this colouring is not bruising but is a result of a build up of cellular debris and stagnation being drawn to the surface.
I agree to keep my therapist informed of any health changes to ensure accurate assessment of whether cupping therapy is an appropriate treatment option is future sessions.

Initial:_____

Please sign below to acknowledge that you have read, understood, and agree to the information provided above:

Print name:_____ Date:_____

Signature: _____

Please note: By signing this form, you confirm you are of legal age or have obtained appropriate consent if you are signing on behalf of a minor or someone else.