MEDICAL MASSAGE CONSENT/POLICIES FORM

Name:____ Date:_________________
FEMALES ONLY: Are you pregnant? □ Y □ N

Specific Reason and Region to be addressed for today's visit:_______________________________

Have you received professional massage therapy before? □ Y □ N

Do you wear contact lenses? □ Y □ N

Any allergies/sensitivities to lotions, scents, foods, detergents, etc…? □ Y □ N
Please explain:____

Please mark any of the following conditions that apply to you, past and present. Explain below as needed.

__Arthritis
__Asthma
__Autoimmune: ________________________
__Blood Clots
__Broken/fractured bones
__Bursitis
__Cancer
__Constipation (chronic)
__Dementia/Alzheimer's
__Depression/Anxiety
__Diabetes
__Dizziness
__Epilepsy
__Fibromyalgia
__Fatigue
__Headaches/Migraines
__Hearing Impairment
__Heart Condition
__High/Low Blood Pressure
__Infectious Disease: ___________________
__Insomnia
__Jaw Pain/TMJD
__Multiple Sclerosis
__Osteoporosis
__Parkinson's Disease
__Spasms/numbness/tingling/swelling
__Scoliosis
__Sciatica
__Spinal Cord Injury
__Stroke
__Skin Conditions (rashes, warts, etc.)
__Tendonitis
__Varicose Veins
__Other: ____________________________

Any painful/sensitive scars, bruises, or wounds? □ Y □ N
Where?______________________________

Additional comments or concerns:____

PLEASE READ:

Consent for Care

It is my choice to receive massage therapy and/or bodywork. I understand that the massage/bodywork that I receive is for the basic purpose of relaxation and relief of muscular tension/pain. I further understand that massage/bodywork is not a substitute for medical care, and my massage therapist does not diagnose conditions/illnesses, prescribe medical treatment, or perform any spinal adjustments. I affirm that I have stated all known medical conditions and answered all questions honestly and completely. I agree to keep the massage therapist informed of my current health status and understand that there shall be no liability on the practitioner's part should I forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be responsible for full payment of the scheduled appointment. By signing this, I waive and release Columbia Family Chiropractic from any and all liability, past, present, or future, related to massage therapy and bodywork performed by any employed or independent contracted LMT working at a Columbia Family Chiropractic location..

Policies

-Tardiness

________ I understand that I am expected to be on time for my appointments.

**If you are late, your massage will be shortened to fit into the scheduled time and full payment will be due.*

-Cancellation

__ I understand full payment is expected for appointments that I cancel/reschedule with less than 24 hours notice or no show/no call.

**Illness or unexpected emergencies will be taken into consideration. Full payment is due at the end of each session.*

Print Name:____ **Date:**______________

Signature:____