MASSAGE THERAPY SERVICE CONSENT FORM

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE

Please note: All first visit charges are payable when services are rendered.

How did you hear about our Wellness Center?_____

Today's date: _____ / _____ / _____

GENERAL INFORMATION

Have you ever experienced a professional massage? _____

Which areas would you like to focus on during this massage? _____

Patient Last Name_____**First**_____**MI**_____

Address_____ **City** _____**State** _____ **Zip** _____

Home Ph: _____**Cell:** _____**Email:** _____

Date of birth _____/_____/_____ **Age** _____ **Height** _____**Weight**_____

Male ☐ **Female** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **# of children**_____

Have you had Chiropractic, Physical Therapy, Occupational Therapy or Speech Therapy this year? ☐ **Yes** ☐ **No**

Which? _____

Referring Physician_____Primary Care Physician_____

Emergency Contact Information:

First/Last Name: _____

Relationship: _____ Primary Phone: _____

HEALTH INFORMATION

Do you have any of the following conditions? If yes, please explain below as clearly as possible.

☐ Stress ☐ Allergies ☐ Contagious disease ☐ Diabetes ☐ Wear contact lenses ☐ Back pain ☐ Pregnant

☐ Cancer ☐ Cardiac/circulatory problems ☐ Arthritis ☐ Sensitive to touch or pressure ☐ Frequent headaches ☐ Osteoporosis ☐ Epilepsy or seizures ☐ Bruise easily

☐ Joint swelling ☐ Varicose veins ☐ Depression ☐ Numbness or stabbing pains? (Explain below)

☐ High blood pressure

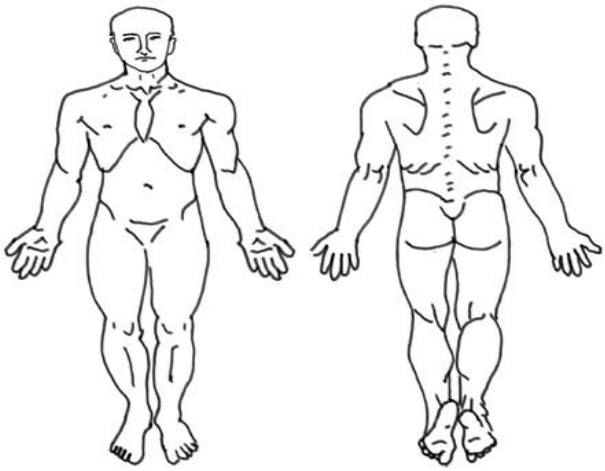
Comments:_____

_____

_____

Please indicate where you are experiencing pain **with a letter** on the involved site. Then indicate your **pain level by circling a number** between 0-10.
(0 = I feel great, 10 = worst pain ever)

A = Ache
B = Burning
N = Numbness
P = Pins and Needles
S = Stabbing
O = Other



Current Pain Level	0	1	2	3	4	5	6	7	8	9	10
Worst in past 24 hours	0	1	2	3	4	5	6	7	8	9	10
Best in past 24 hours	0	1	2	3	4	5	6	7	8	9	10

I 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 the 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. 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 massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. **I authorize Springbok Wellness & Rehab and/or Springbok Chiropractic to release medical information to above named person in the event of an Emergency**

☐ Yes ☐ No

Client's Signature: _____ **Date:** _____ / _____ / _____

Therapist's Name: _____