Barnes Chiropractic Health & Fitness

13890 Braddock Road, Suite 108

Centreville, VA 20121

Consent For Massage Therapy and Office Policy

Massage is contraindicated for some conditions such as blood clots because of risk to the client. Other conditions or disease such as cancer may be negatively affected by massage and required a physician's approval prior to your appointment. Clients with a fever, open wounds, and some skin conditions risk worsening their condition and infecting others by receiving massage. Pain from fibromyalgia, muscle strains, migraines, and arthritis can be lessened or worsened depending on the client's stage of inflammation or healing. An accurate medical history is essential.

It is my choice to receive massage therapy for health maintenance and wellness. I am aware of the benefits and the risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis.

I realize the importance of communication in enhancing the therapeutic effects of the massage. I will not hesitate to inform the massage therapist if any discomfort is felt during the massage and to exchange feedback after the session.

I realize that twenty-four hours notice is required for cancellation of an appointment; otherwise, I will be responsible for the full fee of the massage.

Initial here if you **<u>are willing</u>** to receive confirmation phone calls at home, work or cell or would like to receive e-mail notifications about massage sales or specials.

Home phone_____ Cell phone_____

Work phone_____ E-Mail_____

Signature_____ Date_____

Date: _____

Massage Intake and Health History Form

Name: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Day) _____ (Eve) _____ (Cell) _____

Birth date: _____ Occupation: _____

Primary Care Physician _____ Telephone: _____

Referred by: _____

Have you ever received massage or bodywork? Yes No
If so, what kind? _____

In what type of exercise program or physical activities do you participate and how often? _____

_____

What do you hope to achieve with massage? _____

_____

Emergency Contact Information:

Name: _____ Telephone: (Day) _____ (Eve) _____

Health History:

Do you currently have or have you had any of the following:

	Yes	No	
1. Allergies?	_____	_____	If yes, to what? _____
2. Arthritis?	_____	_____	If yes, where? _____
3. Diabetes?	_____	_____	
4. High Blood Pressure?	_____	_____	
5. Heart Conditions	_____	_____	If yes, please describe. _____
(i.e. heart attack, pacemaker, etc.)	_____	_____	_____
6. Kidney Problems?	_____	_____	If yes, please describe. _____
			_____
7. Cancer/Tumors?	_____	_____	If yes, please describe. _____
			_____
8. Skin condition?	_____	_____	If yes, please describe. _____
(i.e. irritations, infections, or infestations, etc)			_____ Contagious? _____

Are you in treatment for or have any other health conditions not listed above? Please describe.

Have you had any injuries or surgeries? Please describe.

Continued on Other Side →→→→

Date: _____

Have you had any accidents or traumas? Please describe.

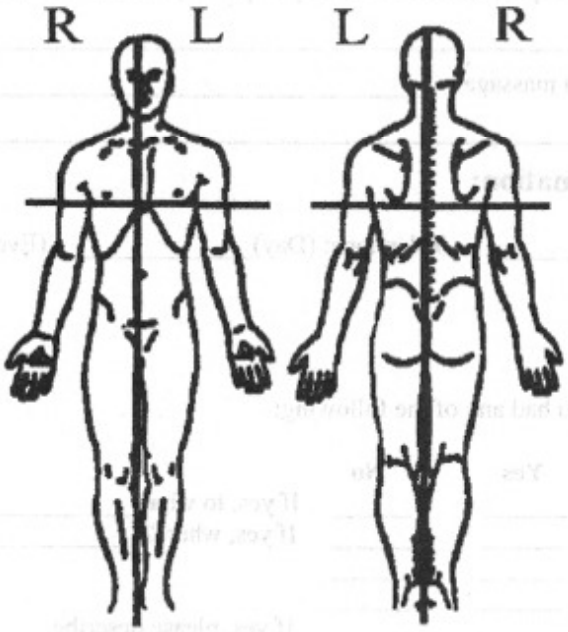
Are you taking any medications? Please list along with known side effects.

Are you pregnant? Yes No If yes, when is the due date? _____

Please indicate the following on the diagram by writing the letter abbreviation in the area of which it occurs

T= Tension
N= Numbness
TG= Tingling
S= Soreness
ST= Stabbing Pain
SH= Shooting Pain
DP= Dull Pain
SW= Swelling

Front Back



What aggravates the symptoms above? What alleviates them?

Please describe anything else that you think may be of importance.