Regional Chiropractic Center

Massage Intake Form

Name: ______________________ **D.O.B:** __________
Address: ____
Phone Number: ____________________ **Email:** ____________________
Occupation: __________________

Emergency Contact:

Name: ____________________ **Phone Number:** ____________________

General and Medical Information

1. Have you ever had a professional massage? YES / NO
2. Are you pregnant? YES / NO How far along? ______________________
3. Are there any sensitive or ticklish areas to avoid? ______________________
4. Do you have any allergies or sensitivity to any oils?
   (essential oils, nut oils, scents, etc). ______________________________
5. Current Medications: (can provide front desk with pre-printed list if easier)

Name of Medication	*Reason for Taking*

6. Any Surgeries?

Type	*Date*

<u>Massage Client Waiver Form:</u>

If I experience pain or discomfort during the session, I will IMMEDIATELY inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

I understand that the services provided are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

I affirm that I have notified my therapist of <u>ALL</u> known medical conditions or injuries

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that massage is <u>ENTIRELY THERAPEUTIC</u> and non-sexual in nature. If a massage therapist feels threatened or is uncomfortable at any time, she/he has a right to end the session and may potentially be terminated as a client.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future, relating to massage therapy and bodywork.

I UNDERSTAND THAT SHOULD I CANCEL AN APPOINTMENT LESS THAN 24 HOURS BEFORE THE SCHEDULED TIME, OR "NO SHOW" AN APPOINTMENT, I WILL BE SUBJECT TO A FEE OF $25.00. THIS FEE IS MY RESPONSIBILITY AND WILL NOT BE BILLED TO INSURANCE. IF THE APPOINTMENT WAS BOOKED UNDER A GIFT-CERTIFICATE, THE CLIENT WILL STILL BE RESPONSIBLE FOR THE FEE.

I have received the policy statement and have read and agreed to the policies therein.

Client Name: ______________________________

Client Signature: ______________________________ **Date:** ____________

Therapist Signature: ______________________________ **Date:** ____________