RAPP CHIROPRACTIC

MASSAGE THERAPY CLIENT INTAKE AND CONSENT FORM

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Birthdate: _____ ❑ Male ❑ Female

Occupation: _____ Referred by: _____

Emergency Contact Name: _____ Phone: _____

Please take a moment to carefully read the following information and sign below. If you have a specific medical condition, or specific symptoms, massage/bodywork may be contraindicated.

Have you ever had a professional massage? ❑ Yes ❑ No How recently? _____

What are your massage or bodywork goals? _____

On a scale of 1-10 what kind of pressure do you prefer? Light ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Firm

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If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you have frequent headaches?
❑ Yes ❑ No Are you pregnant? _____ weeks
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No Taking high blood pressure medication?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Any history of Cancer?
↳ If yes, when were you last treated? _____
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you bruise easily?

❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? Explain below.
❑ Yes ❑ No Any other medical conditions, or medications I should know about?

Comments: _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail 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 liable for payment of the scheduled appointment.

Cancellation Policy: We require 24 hours notice for cancelling or rescheduling. If you do not give sufficient notice you may be subject to prepayment to hold future appointments.

Client Signature: _____ Date: _____