Krista Hall at Trusted Care Chiropractic

MASSAGE CLIENT INFORMATION FORM

______________________________________ Age:__________ or DOB:__________

Please print FULL Name

______________________________________ ______________________________________

Street Address City, State, Zip

______________________ ______________________ ___________________________

Home Phone Cell phone E-mail address

___________________________ X____

Occupation Emergency Contact NAME AND PHONE NUMBER (REQUIRED)

Clinic Policies and Informed Consent:

1. ***All massage services provided in our clinic are performed by a Licenced Massage Therapist.***
2. ***Services received in our clinic are not a substitute for medical care***
3. ***All personal or medical information received from the client is completely private and confidential. Per HIPAA***
4. ***This form and the signature below will serve as legal "Release of Medical Information" for Krista Hall massage therapy to release client's medical records upon client's request for medical and insurance purposes only***
   .
5. ***We do not give cash refunds on any service provided or product sold.***
6. ***Out of respect for all clients, we ask that cell phones be put on silent or turned off, appropriate language be used in a low tone of voice and that children under the age of 12 are not left unattended in the clinic.***
7. ***Sexual misconduct or any inappropriate sexual advances, weather verbal physical or implied, will not be tolerated and will result in the immediate termination of the massage session. Any client exhibiting such behavior will no longer allowed services at this clinic. NO REFUND will be given under these circumstances regardless of the length of the session at point of termination.***
8. ***Other parties that my be responsible for payment and making appointments for this client may be listed below with signature and contact information.***

I fully understand and agree to comply with all clinic policies listed above. Please sign by the X below

___________________ X________________________ ________________________

Date *signature of client* *witness/therapist*

___________________ ________________________ X________________________

Date *Name of minor (18 or younger)* *Parent/ Guardian/ other responsible parties.*

Client Medical History Form:

Client Printed FULL NAME: ________________________ ***Date*** ______________

Please mark the box where applicable to indicate condition(s) if any are currently bothering you:

Skin Disorders: ***N/A ☐***

- ❑ *Acne*
- ❑ *Bruise*
- ❑ *Eczema*
- ❑ *Fungus*
- ❑ *Psoriasis or rash*
- ❑ *Warts*

Treatments for any above conditions?

-____________________

Circulatory Disorders: ***N/A ☐***

- ❑ *Anemia*
- ❑ *Headaches*
- ❑ *Heart attack or Stroke*
- ❑ *High or low blood pressuse*
- ❑ *Varicose veins*

Treatment for any above conditions?

____

Respiratory Disorders: ***N/A ☐***

- ❑ *Emphysema*
- ❑ *Smoke related cough or wheezing*

Treatment for any of the above conditions?

____

Cancer: ***N/A ☐***

Type: ____________________

Treatment: ____________________

Thyroid Dysfunction: ***N/A ☐***

- ❑ *Hyperthyroid*
- ❑ *Hypothyroid*

Treatment for any above conditions?

____

Skeletal Disorders: ***N/A ☐***

- ❑ *Carpal tunnel syndrome*
- ❑ *Osteoporosis*
- ❑ *Osteoarthritis / Rheumatoid Arthritis*
- ❑ *spine/ disc abnormalities*
- ❑ *Sprains*
- ❑ *TMJ or jaw pain*
- ❑ *Tendonitis*

Treatments for any above conditions?

____

Muscular Disorders: ***N/A ☐***

- ❑ *Cramps / spasms*
- ❑ *Fibromyalgia or Myofascial pain*
- ❑ *Muscular distrophy*
- ❑ *Shin splints*
- ❑ *strain(s)*

Treatments for any above conditions?

____

Nervous Disorders: ***N/A ☐***

- ❑ *Anxiety or Clinical Depression*
- ❑ *Multiple Sclerosis or Parkinson's Disease*
- ❑ *Seizures or Epilepsy*

Treatment for any above conditions?

____

Sleep Disorders: ***N/A☐***

- ❑ *Insomnia*
- ❑ *Sleep apnea*
- ❑ *Abnormal sleep pattern*

Treatment for any above conditions?

____

Any other disorders not listed above , or medications please list here:

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Massage client intake form

Clients Full Name:____

The following information will be used to help plan a safe, effective massage session. Please answer to the best of your knowledge.

1. Have you ever had a professional massage before: Yes No If Yes, how often?__________________________
2. Do you have any allergies to oils, lotions, or ointments? or sensitive skin? Yes No
   If yes, Please explain____
3. is there any area of the body you are experiencing tension, stiffness or pain?
   If Yes, please explain:____
4. Have you had any recent injuries or Surgeries? Bone, Tendon or Muscle related?.
   if yes: please explain:____
5. Are you currently under medical supervision? Yes No If yes, please explain:_______
6. Are you on any medications that may affect your massage today? **Blood Thinners, Painkillers/ Anti-inflammatories, Insulin for diabetes, Chemical therapy or Radiation therapy**
7. Have you had any symptoms of contagious illnesses within the past 48 hours?
8. Do you see a chiropractor or physical therapist? Yes No If yes, how often?________
9. Are you or could you be Pregnant: Yes No if yes, How far along?______________

Waiver and Release of Liability

I, ____, *(print name legibly please)* fully understand that I am receiving massage services from a Licensed Massage Therapist. I agree to assume any risk and to release and hold Krista Hall, harmless of any liability should I suffer any damage, loss or injury during massage or bodywork services due to negligence or carelessness. By signing below I guarantee the above medical and personal information is correct and complete, and I voluntarily give up my right to make a claim against Krista Hall.

Clients Signature:____ Date:_______________________