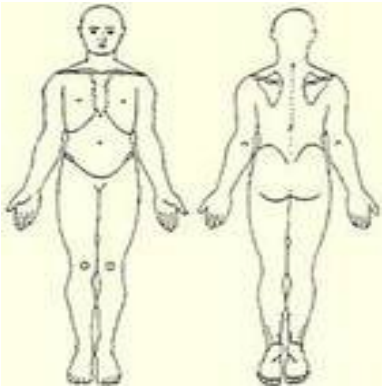
On Centre Chiropractic
Massage Therapy Intake Form

Personal Information:

Name:_____Phone:_____
Address:_____
Email:_____ Date of Birth: _____
Occupation:_____
Emergency Contact: _____ Phone:_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
2. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____
3. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____
Circle any specific areas you would like the massage therapist to concentrate on during the session:



4. Are you currently under medical supervision? Yes No

If yes, please explain:

_____

5. Please list medications you are currently taking

_____

6. Please check any condition listed below that applies to you:

( ) open sores or wounds	( ) heart condition
( ) easy bruising	( ) high or low blood pressure
( ) contagious skin condition	( ) circulatory disorder
( ) allergies/sensitivity	( ) varicose veins
( ) recent accident or injury	( ) atherosclerosis
( ) recent surgery	( ) communicable disease
( ) artificial joint	( ) deep vein thrombosis/blood clots
( ) sprains/strains	( ) cancer
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis	( ) diabetes
	( ) decreased sensation
( ) osteoporosis	( ) back/neck problems
( ) epilepsy	( ) Fibromyalgia
( ) headaches/migraines	( ) TMJ
( ) pregnancy If yes, how many months? _____	( ) carpal tunnel syndrome
	( ) tennis elbow

7. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

Consent:

I,_____ (print name) 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 this 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 and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that payment is due upon services rendered.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

MyoFascial Cupping Consent Form (Optional)

Client: _____

I understand that Myofascial cupping is a fascial technique that uses decompression as apposed to compression, and as a result there may be some red marking and/or bruises that are a result of superficial blood vessels breaking. I have been informed that the bruises may last a day up to a few days (or more) depending on how my body processes them.

IF you have any blood or skin related illnesses/problems please below:

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-

-

I consent to the use of myofascial cupping in my massage treatment. If I feel uncomfortable at any time I will let my massage therapist know immediately, so she can alter or stop her use of the cups.

_____ Date: _____

Signature

Massage & Privacy:

I understand that by obtaining treatment at On Centre Chiropractic, I am submitting my personal health history information to identify indications and/or contraindications for Massage Therapy.

I understand that my personal information will be retained by On Centre Chiropractic and shared with any therapist contracted or employed by On Centre Chiropractic with whom I receive treatment in order that they understand my personal health history, any indications and contraindications for treatment, and previous treatment.

I also understand that my personal information may be viewed by administrative personnel providing support services to therapists at On Centre Chiropractic.

_____ _____

Signature Date