Champion Chiropractic Center Inc.
Deep Tissue, Therapeutic and Pain Management
Massage Client Intake Form

Date Filled out:_____/_____/_____ Date of First Massage Appt:_____/_____/_____

Name:_____ Phone: _____ Text reminders?: ( )Yes ( ) No

Address:_____

City:_____State:_____Zip:_____

Email:_____ Date of Birth:_____

Occupation:_____

Emergency Contact:_____Relationship:_____Phone:_____

Were you referred to us by anyone? If so, who may we thank? _____

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
   If yes, how often do you receive massage therapy?: _____
2. Do you have any difficulty lying on your front, back or side? ( )Yes ( )No
   If yes, what side?:_____
3. Do you prefer a deep,or medium pressure massage?: _____
4. Do you have sensitive skin? ( )Yes ( ) No
5. Do you have any allergies to oils, lotions or ointments? ( )Yes ( )No
   If yes, please explain: _____
6. Are you wearing ( ) Contacts ( ) Dentures ( ) Hearing Aid ( ) None
7. Do you sit for long hours at a workstation, computer or driving? ( )Yes ( )No
8. Do you perform any repetitive movements in your work, sports or hobbies? ( )Yes ( )No
9. If you have **Low Back Pain** may the massage therapist treat your gluteal muscle region ( )Yes ( )No
10. Have you received cupping before? ( )Yes ( )No if yes, any side effects: _____
11. List current medications & the conditions they are treating:

_____

_____

Medical History

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

1. Are you currently under medical supervision? ( )Yes ( )No

   If yes, please explain:_____

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

( ) Contagious skin condition
( ) Open sores or wounds
( ) Infections (Bacterial, Fungal, Viral)
( ) Bruises easily
( ) Recent accident or injury (less than 6 months)
( ) Recent fracture (less than 6 months)
( ) Recent surgery (less than 6 months)
( ) Artificial joint
( ) Diabetes
( ) High or low blood pressure
( ) Heart condition
( ) Taking blood thinners
( ) Swollen glands
( ) Deep vein thrombosis /blood clots
( ) Circulatory disorder
( ) Varicose veins
( ) Anemia
( ) History of Stroke(s)
( ) Thin Skin
( ) Anxiety

( ) Phlebitis
( ) Inflammation
( ) History of fainting
( ) Atherosclerosis
( ) Joint disorder/ Arthritis/ Osteoarthritis/ Tendonitis
( ) Osteoporosis
( ) History of Seizures
( ) Epilepsy
( ) Headaches/ migraines
( ) Cancer in Remission
( ) Active Cancer
( ) Snoring/ Sleep apnea
( ) Sinus drainage issues
( ) Back/ Neck problems
( ) Fibromyalgia
( ) TMJD
( ) Carpal tunnel syndrome
( ) Tennis elbow ( ) Right ( ) Left
( ) Allergies/ sensitivity
( ) Pregnancy if yes, what trimester?_____
( ) Other: _____

Please explain any condition that you have marked above, and **where** they are located.

_____

_____

_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know?

_____

_____

_____

Champion Chiropractic and Wellness Center, Inc.
Confidential Patient Complaint Form

What are your major complaint(s) and Specific area(s) of pain?:

_____

_____

When did the symptom(s) begin?:

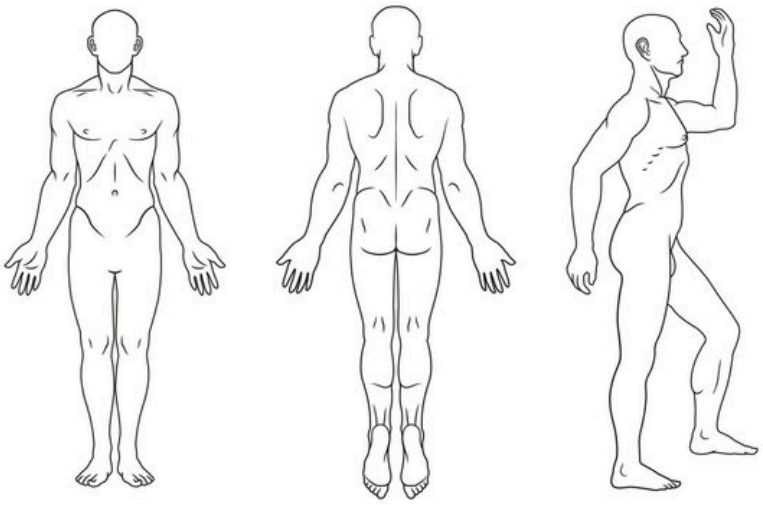
_____

If this is an injury, describe what happened?:

_____

_____

In the body chart below <u>mark</u> the areas that you want worked on.



Have you experienced these symptoms before? ( )Yes ( )No When? _____

What aggravates this condition?_____

What decreases the symptoms/pain? ( )Ice ( )Heat ( )Stretching ( )Nothing ( )Other: _____

_____

Have you seen a doctor for this condition? ( )Yes ( )No

Doctor's Name: _____

Date consulted: _____

Diagnosis: _____

Does this condition interfere with your sleep? ( )Yes ( )No

If yes, how many times do you wake up per night?: _____

In what position do you sleep? ( ) Back ( ) Side ( ) Stomach

Which hand is your dominant hand? ( ) Left ( ) Right

Do you sleep with a pillow? ( )Yes ( )No **If so, how many**?: _____

Does it cause pain to cough, grunt, sneeze? ( )Yes ( )No If so, where?: _____

Champion Chiropractic Massage Agreement

I, _____(**print name**) understand that the massage I receive is provided for the basic purpose of pain management 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. I acknowledge that I should seek 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, diagnoses, give prescriptions, or treat any physical or mental illness. 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.**

_____ _____

(Please Print) Name of Financially Responsible Party Signature of Financially Responsible Party

_____ _____

Relationship to Patient Today's Date

_____ _____

Massage Therapist signature Date

Champion Chiropractic missed appointment & late appointment cancellation Financial Policy.

Our Doctors and therapist value your time and request that you value theirs. The first missed appointment or appointment canceled without a **24 hour** prior notice will receive a warning. No fee will be charged for the first missed appointment. Because we pay our therapist whether you show up or not, **any missed appointments or appointments not canceled with 24 hour notice thereafter will be $60.00 each. These charges cannot be billed to your insurance company and will be your responsibility**. These fees must be paid on or before the next scheduled appointment.

I _____, understand and agree to Champion Chiropractic's missed and or late

cancellation appointment policy.

Signature: _____Date: _____

Informed Consent For Massage Therapy

(Please check or initial each box agreed to below)

- ☐ **If at any point during the massage I am uncomfortable** or uneasy with the procedures being administered and/or I experience pain, I understand it is my responsibility to **IMMEDIATELY inform the massage therapist,** so that the procedure can be adjusted to a level of comfort or terminated. **I will not hold the massage therapist responsible for any discomfort I experience during or after the session.**
- ☐ I further understand that massage therapy is not a substitute for diagnosis and treatment by a medical or osteopathic doctor. What we discuss is not a replacement for their advice. I understand that the massage therapy scope of practice does not include spinal adjustments or the use of drugs, diet or exercise.
- ☐ I understand that if I am under the influence of alcohol or other drugs that inhibit my senses the massage will be terminated immediately.
- ☐ **I agree to provide accurate information about my health history today**, and to tell my massage therapist about any changes in the future. If I do not, it may affect my therapy.
- ☐ Information about massage cupping in general, techniques, potential benefits, effects, risks, after-care recommendations, and possible alternative therapies have been explained to me and **I understand this information.**
- ☐ **I understand that the vacuum formed by cupping may result in marks being left on my body.**
- ☐ My therapist has informed me of the contraindications of cupping therapy, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.
- ☐ I understand and I am aware that there can be side effects to cupping such as nausea/vomiting, fainting, blisters/infections, bleeding, bruising, headaches, dizziness, fatigue, and others.
- ☐ It is not the intent of the massage therapist to cause injury or bruising to the areas of treatment. Minor bruising and soreness is customary after a massage. Drink 40 oz of water to decrease pain and swelling after a massage.
- ☐ **If I have been sick within the last 48 hours, I will reschedule, because massage can make my illness worse.**
- ☐ I acknowledge that any sexual or implied sexual comments or actions on my part will result in immediate termination of the massage session. I will then be fully responsible for any and all charges in full at that time.
- ☐ I authorize this massage therapist to perform the treatment or necessary procedure for myself.
- ☐ I authorize the use of lotions to my body.
- ☐ I acknowledge that I have consulted a physician before undergoing this massage treatment. I understand that I should consult my doctor before the procedure.
- ☐ I understand that this is an alternative treatment and if there are any medical concerns, I need to talk to my physician.
- ☐ I release Champion Chiropractic Center for any responsibility in case of an accident, bruising, illness, or injury.
- ☐ **I acknowledge that all information I provided in this form is true and accurate.**

Signature:_____ Date:_____