Massage Intake and Agreement Form

Name:_____ DOB: _____ Date: _____

Phone Number: (_____) _____Email Address: _____

Street Address:_____

City:_____ State: _____ Zip Code: _____

Reason for coming for massage: ☐ Groupon [Code: _____] ☐ Other: _____

Referred by:_____

Job/Occupation:_____

Do you wear glasses/contacts? ☐ Yes ☐ No

Current Medications/ If any:_____

Emergency Contact: Name: _____ Contact #: _____

If you currently have, or within the last year have had, any of the following Health Conditions please check the box accordingly, if "YES" please give details below or on the back of this page:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Phlebitis
☐ Yes ☐ No Fractures
☐ Yes ☐ No Hematomas
☐ Yes ☐ No Allergies
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Pregnant
☐ Yes ☐ No Surgery

☐ Yes ☐ No Skin condition
☐ Yes ☐ No Herpes
☐ Yes ☐ No AIDS/ARC/HIV+
☐ Yes ☐ No Any contagious disease
☐ Yes ☐ No Epilepsy/seizures
☐ Yes ☐ No Bruise easily
☐ Yes ☐ No Fever
☐ Yes ☐ No Consumed Alcohol (past 24 hrs)
☐ Yes ☐ No High/ Low Blood Pressure

If there are any medical conditions, not listed above, that I should be made aware of, please indicate below._____

_____

Check off any of the symptoms you have experienced in the past year or are currently experiencing:

☐ Tension Headache
☐ Migraine Headache
☐ Neck Pain
☐ Mid-Back Pain
☐ Low-Back Pain
☐ Shoulder Pain
☐ Wrist Pain
☐ Carpel Tunnel
☐ Knee Pain
☐ Numbing/Tingling in arms or hands
☐ Numbing/Tingling in legs or feet
☐ Fibromyalgia
☐ Arthritis
☐ Joint Pain
☐ Weight Gain/Loss
☐ Auto Accident:
_____/_____/_____
(Date of Accident)

Which of the above is worst?_____How long have you had it?_____

Preferred Massage Pressure: (if you are not sure consult with Massage Therapist)

☐ Very Light Pressure ☐ Light Pressure ☐ Medium Pressure ☐ Moderate Pressure ☐ Heavy Pressure

C.O.R.E Health Centers
MEDICAL | CHIROPRACTIC | WELLNESS

Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition/symptoms, massage/ bodywork may be contraindicated. A referral from your physician or care provider may be required before the session can continue.

I, (_____), understand that the massage can be used for many different purposes, including deep tissue bodywork, neuromuscular therapy (NMT), basic relaxation, and/ or relief of muscular tension. I will discuss with my practitioner which type of session is best suited for me.

If I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be misconstrued as a substitute for a 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/ bodywork practitioners are not qualified to perform spinal and/or skeletal adjustments, diagnose, prescribe, or treat any physical/mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/ bodywork 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 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 forget to do so.

It is also understood that any illicit or sexually suggestive remarks or behavior will result in immediate termination of the session, and that the patient will be held liable for payment of the scheduled appointment.

Patient Signature:_____ Date:____/____/_____

Practitioner Signature:_____ Date:____/____/_____

Consent to Treatment of Minor (Under the age of 18):

By my signature below, I hereby authorize _____ to receive massage, and bodywork techniques, as deemed necessary by C.O.R.E. Health Center's Licensed Massage Therapist (LMT).

Signature of Parent/ Guardian:_____ Date____/____/_____