NAME:_____

(Last) (First)

INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of massage therapy by the therapist/technician named below or other therapists/technicians at Caruso Chiropractic. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists/technicians do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services. I accept that massage promises no long-term results nor will it cure my health problems.

The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

If at any time during the massage the client or therapist/technician is uncomfortable for any reason, they shall immediately say so.

Sexual advances of any kind will not be tolerated.

Children are not permitted in the massage room and must have childcare provided for them during the massage. Caruso Chiropractic does not provide childcare services.

Cancellation Policy: A 24-hour notice is required for cancellation of your massage appointment. After one no call no show, you will be billed for the second no call no show. Insurance does not cover no call no show appointments. You will be charged out of your pocket. If you cancel your massage appointment less than 24-hours in advance and your slot is not filled, you will be considered a no call no show.

All information will be kept strictly confidential and will remain with Caruso Chiropractic.

I have read and agree with above information. If I have any questions or concerns, I will let the therapist know right away.

Signature: _____ Date:_____

Therapist/Technician Signature:_____ Date:_____

Massage Client Information Form

Name: _____ Date: _____

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

Phone: (day) _____ (eve) _____ Date of Birth: _____

Occupation: _____ Employer: _____

Referred by: _____ Physician: _____

Previous experience with massage: _____

Primary reason for massage: _____

Emergency contact – name and number: _____

Please mark (X) all conditions that apply now. Put a (P) for past conditions, an (F) for family history of illness

___ headaches, migraines	___ chronic pain	___ fatigue
___ vision problems, contact lenses	___ Muscle or joint pain	___ tension, stress
___ hearing problems, deafness	___ muscle, bone injuries	___ depression
___ injuries to face or head	___ numbness or tingling	___ sleep difficulties
___ sinus problems	___ sprains, strains	___ allergies, sensitivities
___ dental bridges, braces	___ arthritis, tendonitis	___ rashes, athletes foot
___ jaw pain, TMJ problems	___ cancer, tumors	___ infectious diseases
___ asthma or lung conditions	___ spinal column disorders	___ blood clots
___ constipation, diarrhea	___ diabetes	___ varicose veins
___ hernia	___ pregnancy	___ high/low blood pressure
___ birth control, IUD	___ heart, circulatory problems	
___ abdominal or digestive problems	___ other medical conditions not listed	

Explain any areas noted above:

Current medications including aspirin, ibuprofen, herbs, supplements, etc.:

Surgeries:

Accidents:

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation: