DR. DAN
CHIROPRACTIC & MASSAGE

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Therapeutic Massage Questionnaire:

Today's Visit Date ____/____/____ ☐ Male ☐ Female

Name_____ Date of Birth____/____/____ Occupation_____

Address_____ City_____State_____ Zip_____

Cell Phone (_____)_____-_____Cell Carrier _____Email _____

Referred by _____Emergency Contact_____ Phone (_____)_____-_____

The following information will be used to provide comfortable, safe, effective and enjoyable massage sessions.

I enjoy: ☐ No talking during my massage except about complaint areas ☐ Some talking ☐ Talking quite a bit

I enjoy: ☐ Light Pressure ☐ Light – Medium ☐ Medium Pressure ☐ Medium – Deep ☐ Deep Pressure

Yes No If You Mark "Yes" to any of the questions below please explain in the space provided:

☐ ☐ Do you have specific areas you would like treated?_____

☐ ☐ Have you ever had a professional massage? How long ago? _____

☐ ☐ Do you have any difficulty lying on your front, back, or side?_____

☐ ☐ Do you have any allergies to lotions, oils, ointments or fragrances?_____

☐ ☐ Do you have sensitive skin, wear contacts, have dentures or hearing aids?_____

☐ ☐ Are you pregnant? What stage or month?_____

☐ ☐ Do you have varicose veins, blood clots or other vascular problems?_____

☐ ☐ Do you have high blood pressure or other heart problems?_____

☐ ☐ Do you have diabetes, neuropathies or skin lesions?_____

☐ ☐ Do you get headaches? How often & where?_____

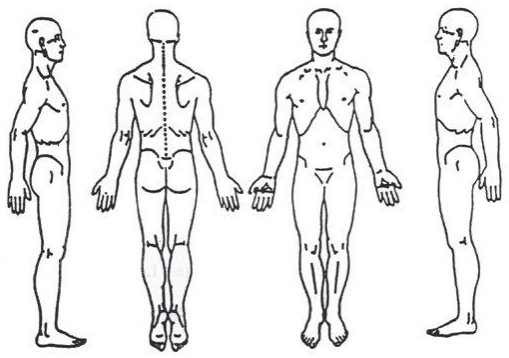
☐ ☐ Do you have arthritis or an infectious or contagious disease?_____

☐ ☐ Are there any repetitive motions you perform during work, sports or recreation?_____

☐ ☐ Are you taking medications or under medical supervision?_____

Please mark all symptoms that apply and locations of current pain, discomfort, injuries, stress or concern you have.

☐ Achy	☐ Tight	☐ Sore
☐ Stiff	☐ Sharp	☐ Dull
☐ Radiating	☐ Burning	☐ Stabbing
☐ Shooting	☐ Pins & Needles	☐ Numbness
☐ Tingling	☐ Spasm	☐ Piercing



Medical History

Please check any conditions listed below that apply to you now or that have applied to you in the past.

- ☐ Open wounds or sores
- ☐ Recent fracture
- ☐ Sprain or strain
- ☐ Allergies or sensitivities
- ☐ Phlebitis (*swelling of a vein*)
- ☐ Deep vein thrombosis / blood clots
- ☐ Decreased sensation
- ☐ Easily bruised
- ☐ Recent surgery
- ☐ Current fever
- ☐ Circulatory disorder
- ☐ Osteoporosis
- ☐ Joint disorder
- ☐ Fibromyalgia
- ☐ Recent accident or injury
- ☐ Artificial joint
- ☐ Swollen glands
- ☐ Atherosclerosis
- ☐ Epilepsy
- ☐ Cancer / Tumor
- ☐ Carpal tunnel syndrome / Tendonitis

Please briefly explain any condition that you have marked above:

_____

_____

Is there anything else about your health history that you feel we should know about to ensure your experience is safe and effective?_____

Please Note: Fabric draping will be used during the session – only the area being worked on will be uncovered. However, massage clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session or they must provide written consent for treatment prior to massage.

I, _____(print name) understand that the massage I receive is provided for the purpose of rehabilitation of soft tissue injury, stress reduction, relief from pain and muscle tension, increased circulation and/or relaxation. I understand the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. They do not prescribe medical treatment, drug prescriptions or spinal manipulations. 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 I may have. I understand that undiagnosed underlying medical conditions may be present and the normal manipulation of soft tissue may aggravate these conditions. I will not hold the massage practitioner or the Clinic liable should this result. 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 there shall be no liability on the therapist's part should I fail to do so.

*** Initials:_____***As a courtesy to our therapists and other patients, we request 24-hour notice if you cancel or reschedule your appointment. Failure to do so will result in a cancellation fee of $45.00. Clients arriving late will still be charged the normal hourly rate.***

H.I.P.P.A. Privacy law and consent for use and disclosure of health information:

We are very concerned with protecting your privacy. In compliance with HIPPA regulations we will never release any of your personal information without your personal written consent. While the law requires us to give you this disclosure, please know that we will always respect the privacy of your health information. You have the right to limit uses and disclosures or revoke your authorization at any time and such limits and restrictions will start from that time forward.

There are several circumstances in which we may have to use or disclose your health care information:

1. Requests from another health care facility or hospital for diagnosis, assessment or treatment.
2. For billing records to another party or law office if they are responsible for the payment of your services.
3. For referral within our practice to another practitioner, for quality control or other operational purposes.
4. To remind you of your appointments, send you email promotions, thank you cards or office news.

Print Name_____ Signature_____ Date_____/_____/_____

Signature of provider or provider representative_____ Date_____/_____/_____