



RAPP CHIROPRACTIC

MASSAGE THERAPY CLIENT INTAKE AND CONSENT FORM

Name: _____ Phone: _____

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

Email: _____ Birthdate: _____ Male Female

Occupation: _____ Referred by: _____

Emergency Contact Name: _____ Phone: _____

Please take a moment to carefully read the following information and sign below. If you have a specific medical condition, or specific symptoms, massage/bodywork may be contraindicated.

Have you ever had a professional massage? Yes No How recently? _____

What are your massage or bodywork goals? _____

On a scale of 1-10 what kind of pressure do you prefer? Light 1 2 3 4 5 6 7 8 9 10 Firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- Yes/No questions: Do you have diabetes? Do you suffer from joint swelling? Do you have frequent headaches? Any broken bones in the past two years? Are you pregnant? Any injuries in the past two years? Do you suffer from arthritis? Do you have cardiac or circulatory problems? Do you have high blood pressure? Do you have numbness or stabbing pains? Taking high blood pressure medication? Sensitive to touch or pressure in any area? Do you suffer from epilepsy or seizures? Have you ever had surgery? Explain below. Any history of Cancer? Any other medical conditions, or medications I should know about? If yes, when were you last treated? Do you have varicose veins? Do you have any contagious diseases? Do you have osteoporosis? Do you have any allergies? Do you bruise easily?

Comments: _____

I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the 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 fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Cancellation Policy: We require 24 hours notice for cancelling or rescheduling. If you do not give sufficient notice you may be subject to prepayment to hold future appointments.

Client Signature: _____ Date: _____