Massage Client Information

Name:_____ Phone:_____ Date of birth: _____

Address:_____ City:_____ Zip code:_____

Age:_____ ☐ Male ☐ Female Your occupation:_____

Referred by:_____ Date of last massage:_____

In case of emergency please call:_____ Phone Number: _____

Please refrain from smoking or wearing perfumes the day of your massage out of respect to other patients who follow your massage and may be allergic.

General & Medical Information

Check any of the following pains you experience:

- ☐ Headaches/Tension
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Digestive disturbance
- ☐ Neck pain
- ☐ Leg pain
- ☐ Arm, wrist or hand pain
- ☐ Jaw pain (TMJ)
- ☐ Hip pain
- ☐ Pain between shoulder blades
- ☐ Ankle, Foot Pain

Do you currently have any of the following:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Varicose vein or artery/vein problems
- ☐ Epilepsy or seizures
- ☐ Contagious disease
- ☐ Osteoporosis
- ☐ Respiratory problems
- ☐ Heat or circulatory disorder
- ☐ Artificial joints/limbs
- ☐ Sinus problems
- ☐ Cold hands/feet
- ☐ Hepatitis/HIV
- ☐ Hernias
- ☐ Inflammatory disease
- ☐ Other:_____
- ☐ Skin abnormalities
- ☐ Multiple sclerosis
- ☐ Aneurysm
- ☐ Blood clots
- ☐ Cancer
- ☐ Kidney/bladder problems
- ☐ Numbness/tingling

Do you currently see a Chiropractor? Yes No

Are you pregnant? Yes No How far along:_____

Have you ever had back surgery? Yes No If yes, where:_____

Do you have any allergies to oils/scents? Yes No Explain:_____

Have you suffered any injuries? Yes No Explain:_____

Are you sensitive to touch/pressure? Yes No Where:_____

Do you bruise easily? Yes No

Please list current medications/supplements:

_____

_____

_____

Please list any medical conditions:

_____

_____

_____

Payment Information

Please Note: We will gladly call your insurance to check your massage benefits. However, per the insurance companies, it is the patient's responsibility to know their benefits and track visit limits. (You can inquire with receptionist as needed.) **PLEASE BE AWARE THAT OUR OFFICE DOES NOT ACCEPT ANY FORM OF MEDICAID INSURANCE.** The benefits provided by your insurance company are not a guarantee of payment. Therefore, although we will file the claims with your insurance company, by signing this you agree that you are responsible for any unpaid portion of services rendered. Any balance due for services are due regardless of results.

Cancellation policy: A 24 hour notice is required for cancellation of your massage appointment. If 24 hour notice is not provided, you will be charged the FULL price. **We cannot bill insurance for services not rendered.*

Patient Signature: _____ Date: _____/_____/_____

Insurance Company: _____ Subscribers Name: _____

Relation: _____ Date of Birth: _____ /_____ /_____

Patient Name: _____

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 Kraft Chiropractic Clinic. 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. Kraft Chiropractic Clinic does not provide childcare services.

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

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

_____ _____
Signature Date

_____ _____
Therapist/Technician Signature Date

Consent for Massage Therapy of a Minor Child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____
Print Name Date

_____
Signature

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that Kraft Chiropractic Clinic's Notice of Privacy Practices has been provided to me. I understand that I have a right to review Kraft Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kraft Chiropractic Clinic. The Notice of Privacy Practices for Kraft Chiropractic Clinic is also provided on request at the main administration desk of this practice and on Kraft Chiropractic Clinic's website at www.kraftchiro.org. This Notice of Privacy Practices also describes my rights and Kraft Chiropractic Clinic's duties with respect to my protected health information.

Kraft Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Kraft Chiropractic Clinic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at time of my next appointment.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Description of Personal Representative's Authority