

# LIONSGATE CHIROPRACTIC CENTER FOR WELLNESS

## Massage Therapy Health History & Release Form

CLIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Appointment Reminders: *(circle one)* Text Email Both None

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Are you a current patient in our office? *(circle one)* Yes No

How did you hear about us? \_\_\_\_\_

### PLEASE CHECK ALL THAT APPLY

- High Blood Pressure/Cholesterol
- Shortness of Breath
- Muscle/Joint Problems
- Surgery in the past 3 months
- Scoliosis
- Fainting/Dizzy Spells
- Heart Attack
- Heart Surgery
- Currently Pregnant
- Pregnant in the past 3 months
- Asthma
- Neck/Back Pain
- Stroke
- Arthritis
- Allergies \_\_\_\_\_
- Topical Allergies

Are there any other conditions that our massage therapist should be aware of? \_\_\_\_\_

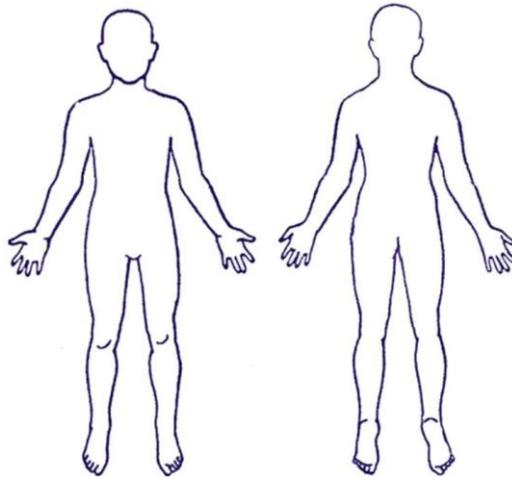
Please rate your stress level: (1 being very low, 5 being very high) 1 2 3 4 5

What are your goals for today's massage? \_\_\_\_\_

Have you received a massage before? Yes No If Yes, How Often: \_\_\_\_\_

**Please circle any areas of focus.**

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Thank you for choosing to use the facilities, services, and programs at Lionsgate Chiropractic. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following statements.

- *I understand that the massage I received is provided for the basic purpose of relaxation, stress reduction, and the relief for muscular pain and tension. It is not intended to replace medical treatment, nor will the therapist offer medical diagnosis.*
- *I understand that I will need to shower prior to my massage.*
- *If I experience any pain or discomfort during the session, I will inform the therapist so that the pressure and technique may be adjusted to my level of comfort.*
- *I understand that talking during the session is at my discretion. The therapist encourages periods of silence with deep, regular breathing to allow for greater relaxation. This will enhance the total body/mind/spirit experience. Deep breathing followed by unrestricted exhaling will release muscle, as well as emotional tension.*
- *I understand that a 24-hour notice is required for schedule changes and cancellations. If I fail to do so, I may be liable for the cost of the appointment missed.*
- *I understand that the massage room is not a place for other individuals, because of the small space, and the interruption factor.*
- *I understand that the therapist may end the massage at any time should I make any sexual remarks or comments that would be considered inappropriate by the therapist. I will also be liable for the charge of the massage regardless of how quickly the massage would be shortened by such circumstances.*

Client Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature \_\_\_\_\_ Employee Initial \_\_\_\_\_