MASSAGE INTAKE

1. Please enter your information.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Gender:
○ Female ○ Male

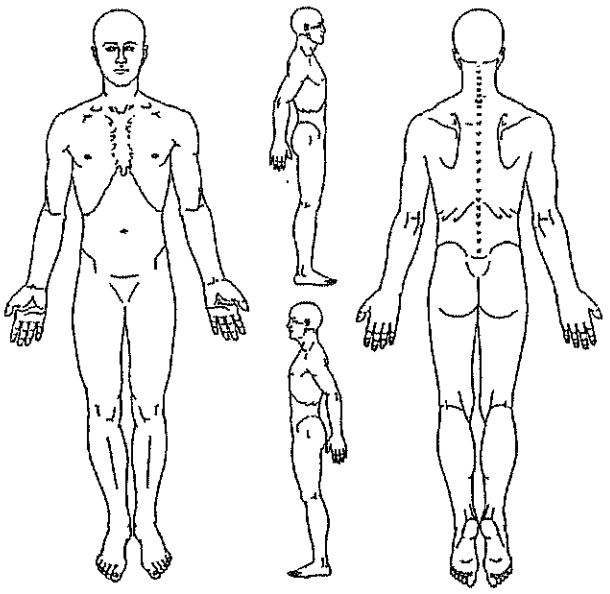
Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

2. Please circle the places bothering you:



3. Please Answer the Following:

Are these the areas you want worked on today?
○ Yes ○ No

Please List any Additional Areas and/or Concerns:

_____

_____

Please List ALL Allergies:

Any History of Car Accidents/Trauma?

Please List all surgeries:

Please List all Medications:

4. Please answer the following:

What is your pain level today? 10 being most severe
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Quality of Pain:
○ Sharp ○ Stabbing ○ Dull Ache ○ Burning ○ Numbness ○ Tingling ○ Tightness ○ Throbbing

When did your pain start?

Do you know what caused it?

Have you had a massage before?
○ Yes ○ No

How long ago was your last massage?

Anything else you would like your massage therapist to know?

Lake City Chiropractic & Massage Center

Dr. Kevin B. Harrison, D.C.

1680 SW Newland Way, Suite 105 – Lake City, Florida 32025

Office: (386) 752-3877 Fax: (386) 752-3544

NAME: _____ **DOB:**_____

If the patient is a minor, we ask that his/her parent or legal guardian sign on behalf of the patient. Thank you!

AUTHORIZATION TO TREAT

I, _____, **(Print Name)** hereby consent to treatment from a Licensed Massage Therapist employed by Dr. Harrison to perform massage therapy as they deem necessary.

Sign:_____

Date:_____

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If the patient is a minor, we ask that his/her parent or legal guardian sign on behalf of the patient. Thank you!

As of this year, the State of Florida asks for your consent for your Licensed Massage Therapist to treat any of the areas/muscles below the waist and above the knees.

I _____, (Print Name) **give my consent** for these areas to be treated if it is beneficial for my treatment plan.

I _____, (Print Name) **do not give my consent**, and would prefer that these areas are not massaged.

Sign:_____

Date:_____

Hot Stone Massage - Consent and Release Form

About Hot Stone Massage

Hot stone massage is a type of massage therapy that uses smooth, heated stones to provide a relaxing and warming effect to a therapeutic massage. The therapist will typically hold a heated stone in each hand while applying various massage techniques such as long gliding strokes, vibration, friction, deep tissue techniques, or trigger point therapy. Using the heated stones as a tool in this way enables the client to benefit from the physiological effects of pressure and heat.

Contraindications for Hot Stone Massage

Please circle if you have any of the following:

In addition to the standard contraindications for massage, hot stone massage has additional contraindications and precautions. The following is a *partial* list of common conditions which are considered contraindications or precautions for hot stone massage:

- Blood clot
- Hematoma
- Cancer
- Diabetes
- Pregnancy
- Injured areas
- Infections
- Neuropathy
- Sunburn / rash
- Heat sensitivity
- Impaired sensation
- Cardiovascular disease
- High/low blood pressure
- Bleeding disorder
- Certain medications
- Phlebitis / varicose veins
- Autoimmune conditions
- Edema / lymphedema
- Skin lesions or open wounds
- Acute injuries or conditions

Please Read and Initial Each Item Below

_____ Information about hot stone massage, potential benefits, effects, risks, and possible alternative therapies have been explained to me and I understand this information.

_____ My therapist has informed me of the contraindications of hot stone massage, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_____ I understand that the temperature of the stones should always be within my comfort level, and I agree to communicate to my therapist about any physical discomfort that I experience during the session.

_____ I have been given an opportunity to ask questions about hot stone massage and have had my questions answered to my satisfaction.

_____ I have no contraindications for hot stone massage.

_____ I release the massage therapist and business from all liability for any harm that may unintentionally result from this treatment.

I further understand that hot stone massage is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken.

By signing this form I agree with the statements above and give my consent to proceed with hot stone massage.

_____ _____/_____/_____

Client Name (Please Print) Date

Cupping Therapy - Consent and Release Form

About Cupping Therapy

Cupping is a therapeutic technique that comes from traditional Chinese medicine (TCM) and is believed to have numerous health benefits in addition to stimulating the flow of qi ("life force") within the body. This body treatment integrates well with massage therapy, and involves applying a localized negative pressure (suction) to the skin using glass, plastic or silicone cups at targeted areas of the body. The intent of this therapy is to stimulate the function of the circulatory and lymphatic systems. It may also help to release congested tissues and loosen adhesions at superficial tissues of the body.

Contraindications for Cupping Therapy

Please circle if you have any of the following:

The following is a partial list of common conditions which are considered contraindications for cupping therapy:

- Blood clots
- Bleeding disorders
- Bruise easily
- Hemophilia
- Injured areas
- Infections
- Acute skin conditions
- Sunburn / rash
- Skin lesions
- Cancer
- Areas of herniation
- Hematomas
- Phlebitis / varicose veins
- Impaired sensation
- Edema / lymphedema
- Certain medications

Please Read and Initial Each Item Below

_____ Information about massage cupping in general, techniques, potential benefits, effects, risks, after-care recommendations, and possible alternative therapies have been explained to me and I understand this information.

_____ I understand that the vacuum formed by cupping may result in marks being left on my body.

_____ My therapist has informed me of the contraindications of cupping therapy, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_____ I agree to communicate to my therapist any physical discomfort experienced during the session.

_____ I have been given an opportunity to ask questions about cupping therapy and have had my questions answered to my satisfaction.

_____ I am not taking blood thinners, and I have no contraindications for cupping therapy.

_____ I release the massage therapist and business from all liability for any harm that may unintentionally result from this treatment.

I further understand that massage and cupping therapy is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken.

By signing this form I agree with the statements above and give my consent to proceed with cupping therapy.

_____ _____/_____/_____

Client Name (Please Print) Date

Appointment Agreement

I, _____(Print Name)
understand that my appointment, chiropractic and/or massage therapy, is valuable to Dr. Harrison and the Lake City Chiropractic & Massage Center staff. Therefore, I agree that I am responsible for any fees or consequences that may be subjected to me if I miss my appointment, or do not cancel my appointment at least 24 hours prior to my scheduled appointment time.

Failure to cooperate with office polices may result in office dismissal.

_____ _____

(Please Sign) (Date)