MASSAGE
FLC
pure & simple

CLIENT INFORMATION

NAME: _____ PHONE: (____) _____ DOB: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

EMAIL: _____

REFERRED BY: _____PHONE: (____) _____

IN CASE OF EMERGENCY: _____PHONE: (____) _____

OCCUPATION: _____ _____ PHYSICIAN: _____

HEALTH INSURANCE CARRIER: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

HAVE YOU EVER EXPERIENCED A PROFESSIONAL MASSAGE OR BODYWORK SESSION? ☐ YES ☐ NO

WHAT ARE YOUR MASSAGE OR BODYWORK GOALS? _____

WHAT KIND OF PRESSURE DO YOU PREFER? ☐ LIGHT ☐ MEDIUM ☐ FIRM

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

☐ Yes ☐ No Do you frequently suffer from stress?

☐ Yes ☐ No Do you have diabetes?

☐ Yes ☐ No Do you experience frequent headaches?

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Do you suffer from epilepsy or seizures?

☐ Yes ☐ No Sensitivity to pressure?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Do you have high blood pressure?

☐ Yes ☐ No Are you taking high blood pressure medication?

☐ Yes ☐ No Do you have osteoporosis?

☐ Yes ☐ No Do you have allergies?

☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Any broken bones in the past

☐ Yes ☐ No Any injuries in the past 2 yrs?

☐ Yes ☐ No Do you suffer from arthritis?

☐ Yes ☐ No Any cardiac problems?

☐ Yes ☐ No Any numbness or tingling?

☐ Yes ☐ No Any recent surgeries?

☐ Yes ☐ No Do you suffer from joint swelling?

☐ Yes ☐ No Do you have varicose veins?

☐ Yes ☐ No Do you have any contagious diseases?

☐ Yes ☐ No Other medical conditions?

☐ Yes ☐ No Taking medications?

Please explain any questions that you answered "yes" to:

_____

_____

_____

I understand that the massage/bodywork I receive 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)

If I experience any pain or discomfort during session, I will inform the therapist so that the pressure and technique may be adjusted to my level of comfort.

I understand that payment is due at the time of treatment unless other arrangements have been made.

I agree to give 24 hours advance notice of cancellation. If notice is not given, I will be responsible for payment for the time reserved for me.

Signature_____ Date_____

Print_____

Consent to Treatment of Minor: By my signature below, I hereby authorize Finish Line Chiropractic to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian

_____

Date _____