

NAME: _____
(Last) (First)

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 Caruso Chiropractic. 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. Caruso Chiropractic does not provide childcare services.

Cancellation Policy: A 24-hour notice is required for cancellation of your massage appointment. After 2 cancellations, you will be billed for the 3rd cancellation if your slot is not filled. No call, no shows will not be rescheduled after their 2nd no call, no show.

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

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

Signature: _____ Date: _____

Therapist/Technician Signature: _____ Date: _____

Massage Client Information Form

Name: _____ Date: _____

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

Phone: (day) _____ (eve) _____ Date of Birth: _____

Occupation: _____ Employer: _____

Referred by: _____ Physician: _____

Previous experience with massage: _____

Primary reason for massage: _____

Emergency contact – name and number: _____

**Please mark (X) all conditions that apply now. Put a (P) for past conditions,
an (F) for family history of illness**

- | | | |
|--|--|---|
| <input type="checkbox"/> headaches, migraines | <input type="checkbox"/> chronic pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> vision problems, contact lenses | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> tension, stress |
| <input type="checkbox"/> hearing problems, deafness | <input type="checkbox"/> muscle, bone injuries | <input type="checkbox"/> depression |
| <input type="checkbox"/> injuries to face or head | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> sprains, strains | <input type="checkbox"/> allergies, sensitivities |
| <input type="checkbox"/> dental bridges, braces | <input type="checkbox"/> arthritis, tendonitis | <input type="checkbox"/> rashes, athletes foot |
| <input type="checkbox"/> jaw pain, TMJ problems | <input type="checkbox"/> cancer, tumors | <input type="checkbox"/> infectious diseases |
| <input type="checkbox"/> asthma or lung conditions | <input type="checkbox"/> spinal column disorders | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> constipation, diarrhea | <input type="checkbox"/> diabetes | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> hernia | <input type="checkbox"/> pregnancy | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> birth control, IUD | <input type="checkbox"/> heart, circulatory problems | |
| <input type="checkbox"/> abdominal or digestive problems | <input type="checkbox"/> other medical conditions not listed | |

Explain any areas noted above:

Current medications including aspirin, ibuprofen, herbs, supplements, etc.:

Surgeries:

Accidents:

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:
