Radix Chiropractic
Client Intake Form – Therapeutic Massage

Name _____ Phone (Day) _____ Today's Date _____

Address _____

City/State/Zip _____

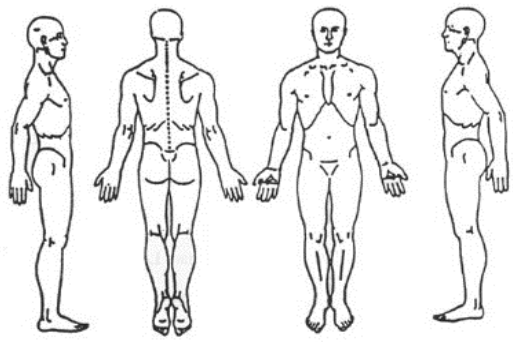
Email _____ Date of Birth _____ Occupation_____

Emergency Contact _____ Phone _____

Please answer the following questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No
   If Yes, how often do your receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If Yes, please explain: _____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If Yes, please explain: _____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If Yes, please describe: _____
7. Do you perform any repetitive movement in your work, sports, or hobbies? Yes No
   If Yes, please describe: _____
8. Do you experience stress in your work, family, or other aspects of your life? Yes No
   If Yes, how do you think it has affected your health?
   Muscle Tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other _____
9. Is there a particular area of the body where you are experiencing tension stiffness, pain, or other discomfort? Yes No
   If Yes, please identify: _____
10. Do you have any particular goals in mind for this massage session? Yes No
    If Yes, please explain: _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Client Signature: _____Date: _____ Therapist Initials: _____

Radix Chiropractic
Medical History

In order to plan a massage session that is safe and effective, please provide some general information about your medical history.

11. Are you currently under medical supervision?
    If Yes, please explain: _____
12. Do you see a Chiropractor? Yes No If Yes, how often? _____
13. Are you currently taking any medications? Yes No
    If Yes, please list: _____
14. Please check any condition listed below that applies to you:

    ( ) contagious skin condition
    ( ) open sores or wounds
    ( ) easy bruising
    ( ) recent accident or injury
    ( ) recent fracture
    ( ) recent surgery
    ( ) artificial joint
    ( ) sprains/strains
    ( ) current fever
    ( ) swollen glands
    ( ) allergies/sensitivity
    ( ) heart conditions
    ( ) high or low blood pressure
    ( ) circulatory disorder
    ( ) varicose veins
    ( ) atherosclerosis
    ( ) phlebitis
    ( ) deep vein thrombosis/blood clots
    ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
    ( ) osteoporosis
    ( ) epilepsy
    ( ) headaches/migraines
    ( ) cancer
    ( ) diabetes
    ( ) decreased sensation
    ( ) back/neck problems
    ( ) Fibromyalgia
    ( ) TMJ
    ( ) carpal tunnel syndrome
    ( ) pregnancy If Yes, how many months? _____

    Please explain any condition that you have marked above: _____
    _____
    _____
    _____

15. Is there anything else about your health that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____
    _____

Client Signature: _____Date: _____ Therapist Initials: _____

Radix Chiropractic
Massage Therapy Terms of Acceptance

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

Vitality Membership Only: By initialing and signing below, I understand that I am responsible to give the massage therapist at least 4 hours' notice of cancellation if I am unable to make my massage appointment. Notice of cancellation can be provided over the phone or sent to info@radixchiro.com. If sufficient notice is not received within four hours of my appointment, I understand that Radix Chiropractic has the authorization to charge my debit or credit card on file for up to the full amount of services rendered. Initials: _____

I, _____ (print name), understand that the massage I receive is provided for therapeutic purposes and/or relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, Chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name: _____

Client/Guardian Signature: _____

Date: _____

By signing above, I agree that I have read the above, understand it fully, and choose to receive massage therapy based on these terms.

<u>If applicable, please sign below:</u>

Consent to Perform Massage Therapy on a Minor: I, _____, acknowledge that I am the parent or legal guardian of _____, and hereby great permission for my child to receipt massage therapy at Radix Chiropractic.

Massage Therapist Signature: _____ Date: _____