Axis Rehab & Chiropractic - Massage Therapy

Date ____________________

Patient Name: ____ Date of Birth:______________

Address: ____

City: ____________________________________ State: __________ Zip: ___________________

Email Address: ____

Phone: (Cell)__________________________________ (Work) _____________________________

Emergency Contact: ___________________________________ Phone: ______________________

Relationship: ____

Is this your first professional massage? Y / N

If no, how frequently do you receive a massage? _______________________________________

Primary Complaint? ____

What are your goals for today's massage? ____

MEDICAL HISTORY:

Describe any injuries, surgeries, hospitalizations:____

Are you currently under the care of a physician for these events/injuries? Y / N

If yes, with whom? ____

Are you receiving any other type of treatment? Y / N Explain:__________________________

Please list any medications (prescription and non-prescription) taken now or at regular intervals and explain what the medication is used to treat: ____________________________________

____

Allergies:____

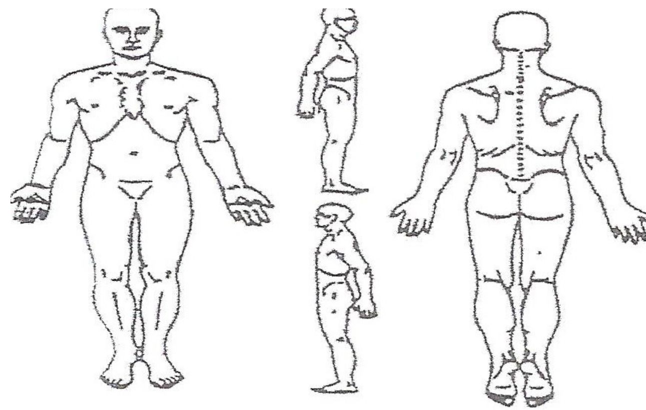
Reactions to skin care products to include massage oils, lotions or ointments?______________

Do you exercise? Y / N If so, how often? ______________Type of exercise? ______________

Alcohol? Y / N If so, how much? ____

How many hours do you sleep each night? _________ In which position? _________________

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark X for pain and/or discomfort:



Describe any chronic pain/tension: ____

____

What specific areas would you like to focus on or stay away from?___________

____

Please check any of the following that apply - Past of Present

__ Heart Problems	__ Chronic Fatigue	__ Spinal Problems
__ Blood Pressure	__ Lupus	__ Disc Problems
__ Varicose Veins	__ AIDS	__ Joint Problems
__ Major Illness/Disease	__ Arthritis	__ Whiplash
__ Neurological Issues	__ Osterarthritis	__ Headaches
__ Blood Clots	__ Back/Neck Pain	__ Diabetes
__ Epilepsy or Seizures	__ Pregnant	__ Skin Conditions
__ Auto-Immune Disorders	__ Pacemaker	__ Bruise Easily
__ Fibromyalgia	__ Cancer	__ Sleep Issues
__ Constipation/Diarrhea	__ Depression	__ Anxiety

Other Issues: ____

The following physiological responses may occur during a massage.
They are normal responses to relaxation.
Trust your body to express what it needs.

- Need to move or change positions
- Sighing, yawning, change in breath
- Stomach gurgling
- Emotional feelings and/or expressions
- Movement of intestinal gas
- Energy shifts
- Falling asleep
- Memories

Our policy is to exceed your expectations and provide the very best massage experience for you.

If you feel as though your massage was a pleasant experience, you may express your satisfaction with gratuity.

Gratuities are always appreciated, but not expected.

Gratuity may be accepted in the form of cash, Venmo, and Zelle.

Feedback is always welcome!

Axis Rehab & Chiropractic ~ Massage Consent Form

By signing this consent form, I understand that Axis Rehab & Chiropractic Massage Therapists do not diagnose illness, disease, or any mental disorder and do not provide medical treatment or pharmaceuticals of any kind. I understand that any services provided by Axis Rehab & Chiropractic practitioners are not a substitution for medical treatment and I should seek the assistance of a physician for any medical concerns.

Further, I understand therapeutic massage treatments provided are intended to enhance relaxation, aid in the reduction of pain, increase range of motion, improve circulation, and offer a positive experience of touch. If during my interaction with any Axis Rehab & Chiropractic therapist, I make any illicit or sexual remarks and/or advances, the massage session will terminate immediately, and I will be responsible for the full payment of the scheduled treatment.

Due to a number of contraindications of therapeutic massage, I affirm and attest that I have answered all of the medical questions to the best of my knowledge. Also, I will take it upon myself to keep all Axis Rehab & Chiropractic therapists informed of any medical changes. Therefore, I assume all risk for my health and hold harmless Axis Rehab & Chiropractic practitioners or any person involved in services performed.

Furthermore, I give full consent to receive therapeutic massage therapy. Also, I am aware that Axis Rehab & Chiropractic practitioners welcome and encourage any questions, concerns, or comments about services and procedures offered.

Finally, I acknowledge that Axis Rehab & Chiropractic maintains a 24-hour Cancelation Policy for all massage therapy appointments. I will be responsible for the Missed Appointment Fee of $50.00, if notification is made less than 24 hours. In addition, I understand that if I arrive late for my appointment, my massage session will end at the originally scheduled time and I am responsible for the full payment.

Name (Print) ____

Signature ____

Date ____