Achieve Health Chiropractic Clinic
13911 Ridgedale Dr. Ste. 200
Minnetonka, MN 55305
952.545.3839, fax 952.546.0168

Massage Client Information

Name _____ DOB _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ ☐ Check the box if you would like to receive important clinic updates, health and wellness information and much more through our online newsletter.

Contact In Case of Emergency _____ Phone _____

Referred By _____Phone _____

General and Medical Information

Occupation _____ ( ) Male ( ) Female, Physician _____

Please take a moment to carefully read the following information on this page and the reverse page 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, How Recently? _____

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 arthritis?
Yes / No Are you wearing contact lenses?
Yes / No Are you wearing dentures?
Yes / No Do you have high blood pressure?
Yes / No If "yes" to previous question, are you taking medication for it? _____
Yes / No Do you suffer from epilepsy or seizures?
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 Do you have osteoporosis?
Yes / No Do you have any allergies?

Yes / No Do you bruise easily?
Yes / No Have you had any broken bones in the past? When?_____
Yes / No Have you been in an accident or suffered any injuries in the past two years? _____ When? _____
Yes/ No Do you have tension or soreness in a specific area? Please specify _____
_____
Yes / No Do you have cardiac or circulatory problems?
Yes / No Do you suffer from back pain?
Yes / No Do you have numbness or stabbing pain anywhere?
Yes / No Are you very sensitive to touch or pressure in any area?
Yes / No Have you ever had surgery? Please explain _____
_____
Yes / No Do you have any other medical condition, or are you taking any medications we should know about? _____
Comments _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or any qualified medical specialist for any mental or physical aliment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in course of the session given be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

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

Signature of Parent or Guardian _____ Date _____

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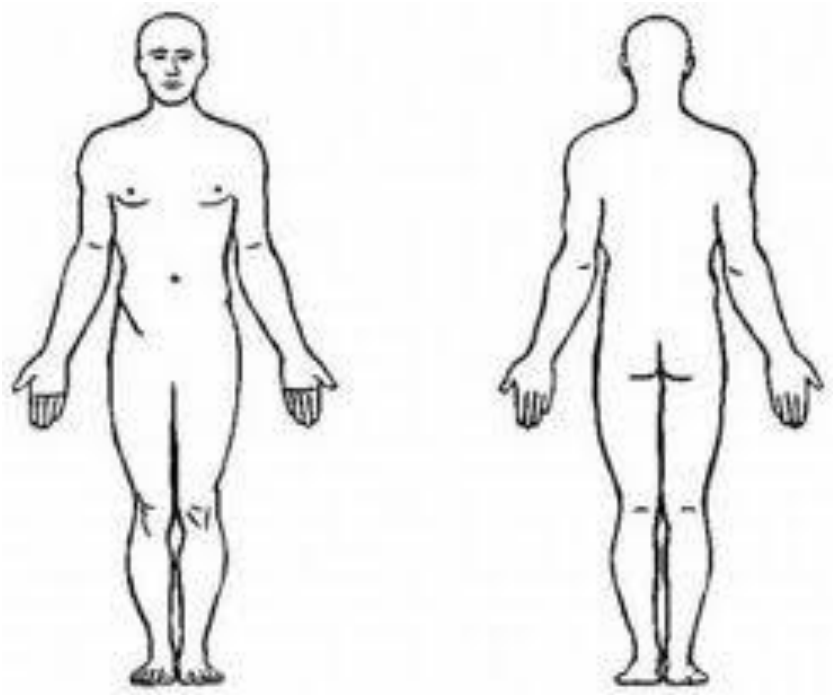

X	Muscle Tension	Place an X over any muscle area of concern.
~	Scars	Place a zigzag over areas where you have scars, regardless of how old. Include C-sections, vaccinations, surgeries, tattoos, cosmetic surgeries. Note approx. age of when you got each one.
O	Surgery	Circle the location of any surgeries, including exploratory, laparoscopies etc. Include year of each.
□	Internal Metal	Put a square around any internal metal objects, such as surgical pins, metal plates, hip replacements etc.
▲	Warts	Place a triangle over any existing warts.

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January 1, 2015

Dear Achieve Health Chiropractic Clinic Patients for Massage Therapy,

We are implementing an appointment cancellation policy for our massage therapy department. Starting January 1st, 2015, for every missed massage therapy appointment there will be a $25 fee. Our goal is to be able to accommodate everyone who visits our office and part of this goal is to have available sessions for our patients to take advantage of our massage therapy services.

There will be one exception to this rule. If you call within 24 hours and reschedule your appointment, we will wave this fee. The appointment must be made within one month and in accordance with your treatment plan.

If you have any questions regarding this policy, please contact us at Achieve Health Chiropractic Clinic. We also would love to hear your feedback regarding the massage therapy and the therapists, including what we can do to serve you better and making sure your needs are being met. We truly appreciate all of our patients, thank you for understanding.

_____
Date

_____
Patient Signature