Massage Therapy Intake & Release Form

Rollette Chiropractic Center
2108 Rue Simone, Hammond, LA 70403
(985) 345-9504

PERSONAL DATA

NAME: _____

ADDRESS: _____CITY/STATE: _____ZIP:_____

PHONE: _____ DATE OF BIRTH: _____/_____/_____

EMERGENCY CONTACT INFORMATION:

NAME: _____PHONE: _____ RELATIONSHIP: _____

OCCUPATION: _____

Have you received massage before? _____

____Yes, I would like to receive emails about massage specials & tips

E-MAIL: _____

____No, I am not interested in receiving emails

How did you find our office? _____

If you were referred, whom may I thank for referring you? _____

HEALTH DATA

Reason for visit: _____

Any physical discomforts or recent injuries: _____

Any specific movement or activity associated with this discomfort: _____

_____

Any recent illnesses or surgeries? _____If yes, please explain: _____

If female, are you pregnant? ____ If yes, current trimester: 1 2 3

Allergies: _____

Currently taking any medications: ____If yes, please indicate type and purpose:

_____

Please check any/all that apply to you:

__Arthritis __Diabetes __Headaches __Varicose Veins

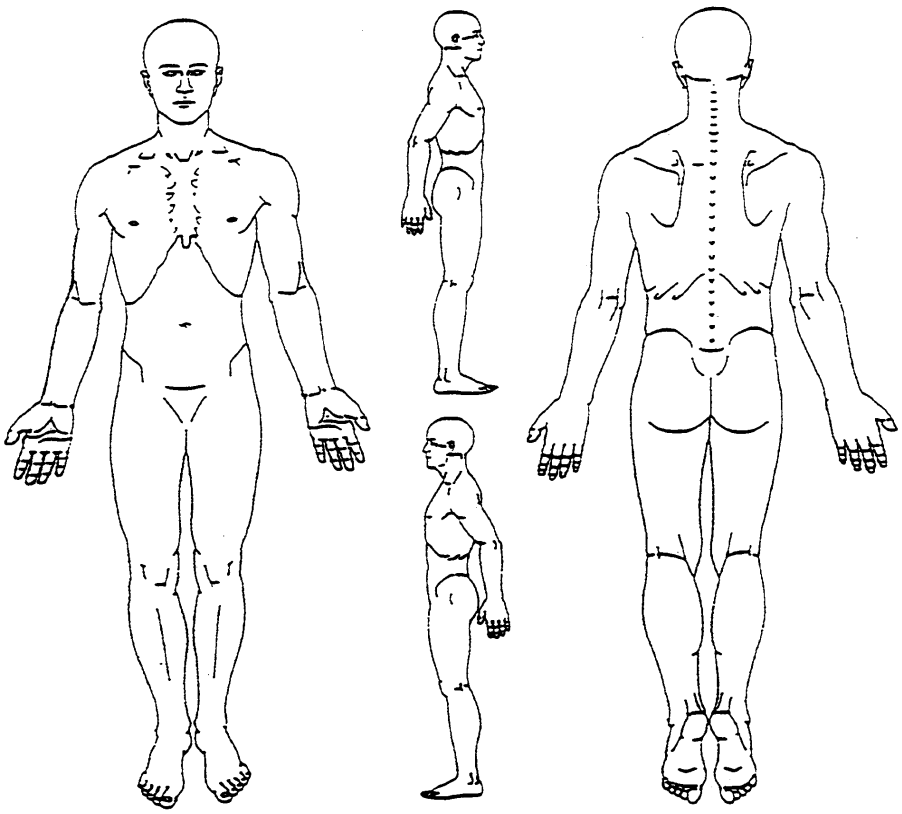
__Bruise easily __Disc Problem __High Blood Pressure

__Cancer __Heart Condition __Osteoporosis

Please list any other medical condition(s) of which I should be aware: _____

_____

Please circle current problem areas on the diagram below:



Client Comments: _____

_____

Informed Consent: Please take a moment to carefully read the following and sign where indicated.
The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. Since massage should not be performed under certain medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning therapy. 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. 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. 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.

Cupping Therapy Release Statement: I have been provided with information on cupping therapy. If I choose to experience this therapy, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a skin discoloration. I am aware that this is not bruising, but due to cellular debris, pathogenic factors, and toxins being drawn to the surface to be cleared away by my circulatory system, and that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.

☐ **I agree to allow the Massage Therapist to perform cupping therapy on me.**

Signature: _____Date: _____

Signature of Parent/Guardian of minor: _____ Date:_____