Massage Therapy Patient Form

Atwell Family Chiropractic
1811 Virginia Avenue, Harrisonburg, VA 22802

Please fill out the following information. Please print clearly.

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
E-mail Address: _____
Employer: _____ Occupation: _____

How did you hear about us? ☐ Yellow Pages ☐ Flyer/Ad: _____ ☐ Other: _____
☐ Friend: _____ (So we may thank them)

If you are currently have or had any of the following conditions, please check them below and discuss them with your massage therapist before your massage begins. Please also inform your massage therapist if you are currently under medical care or taking any medications.

Medical History

____ Heart Disease/Stroke/Heart Attack
____ Arteriosclerosis
____ Varicose Veins
____ Phlebitis/Blood clot/DVT
____ Carpal Tunnel Syndrome
____ Sleep Problems
____ Headaches/Migraines
____ Cancer/Malignancy/Tumor
____ Seizures/Fainting Spells
____ Tendonitis/Bursitis
____ Numbness or Tingling
____ Chemotherapy/Radiation
____ Fibromyalgia/Chronic Fatigue Syndrome
____ Osteoporosis/Scoliosis
____ Rheumatoid Arthritis
____ Herniated or Ruptured Disc
____ PMS/Painful Menstruation
____ Easy Bruising
____ Inner Ear Problems
____ Skin Rash
____ Skin Sensitivity
____ Joint Pain/Replacement/Dislocation
____ High/Low Blood Pressure
____ Recent Sprains/Strains
____ Cortisone Injection
____ Allergies
____ Osteoarthritis
____ AIDS/HIV
____ Fibrosis
____ Kidney Disease
____ Swelling
____ Lupus
____ Diabetes
____ Nausea
____ Inflammation
____ TMJ Syndrome
____ Other (Please List) _____

Any Surgery/Injury within the last 6 months? (Please include dates.)
_____
Do you experience any difficulty lying either on your front or back? _____
Are you allergic to any oils or fragrances? If yes, please list. _____
_____
Is there any chance you might be pregnant? _____
Please list any prescriptions or over-the-counter drugs you are currently taking.
_____
_____
Are you under a doctor's care for any reason? _____
May I have consent to speak with your Doctor if the need arises? _____
Physician's name and phone number: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

The information I have provided is accurate and complete to the best of my knowledge. I understand that this work does not constitute medical treatment, but rather is a form of health maintenance utilizing the techniques and principles of traditional Swedish massage, Deep Tissue Therapy and Myofascial Release. I take responsibility for alerting my massage therapist to any physical conditions that would affect this treatment or of any changes in my health status, medications and therapies before the session or any future sessions.

I understand that I must give at least 24 hour notice to cancel a treatment, unless in case of an emergency. If I am purchasing massage/spa services and are unable to give 24 hour notice to cancel my appointment, I will be charged the full treatment fee. If I am utilizing a gift certificate and are unable to give 24 hour notice to cancel my appointment, that I will be charged $50 per hour that the treatment was scheduled. I also understand that if I am running late for my scheduled appointment, the amount of time that I am late will be deducted from my treatment time and I will be charged the full amount.

Signed _____ Date _____