WELLCARE CHIROPRACTIC CENTER
THERAPEUTIC MASSAGE REGISTRATION

Personal Information:

Name ______________________ Phone (Day) ______________________ Phone (Eve) ______________________

Address ____

City/State/Zip ____

email ______________________ Date of Birth ______________________ Occupation ______________________

Emergency Contact ____ Phone ______________________

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No

   If yes, how often do you 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 hobby? Yes No

   If yes, please describe ________________________________

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ________________________________

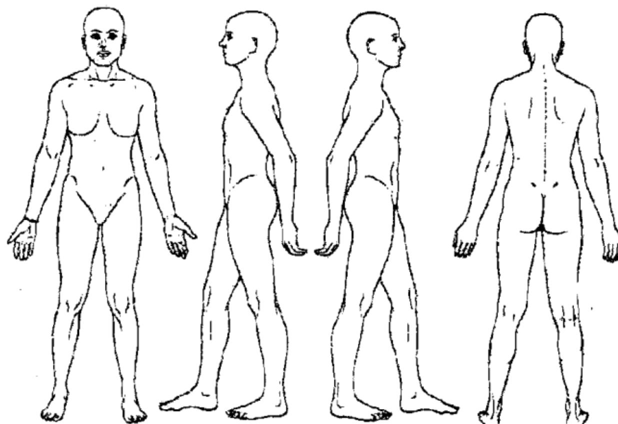
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   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 massage therapist to concentrate on during the session:



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Medical History

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

11. Are you currently under medical supervision? Yes No

If yes, please explain ______________________________

12. Do you see a chiropractor? Yes No If yes, how often? ______________________________

13. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis	( ) high/low blood pressure
( ) open sores or wounds	( ) deep vein thrombosis/blood clots	( ) carpal tunnel syndrome
( ) easy bruising	( ) joint disorder	( ) Rheumatoid/osteoarthritis
( ) recent accident or injury	( ) osteoporosis	( ) circulatory disorder
( ) recent fracture	( ) epilepsy	( ) tennis elbow
( ) recent surgery	( ) headaches/migraines	( ) tendonitis
( ) artificial joint	( ) cancer	( ) varicose veins
( ) sprains/strains	( ) diabetes	( ) artherosclerosis
( ) current fever	( ) decreased sensation	( ) pregnancy
( ) swollen glands	( ) back/neck problems	( ) heart condition
( ) allergies/sensitivity	( ) Fibromyalgia	( ) TMJ disorder

Please explain any condition that you have marked above ______________________________

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

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***Draping will be used during the session – only the area being worked on will be uncovered.
***Clients under the age of 18 must be accompanied by a parent or legal. Informed written consent must be provided by parent or legal guardian for any client under the age of

Consent to Treat

I,______________________________(print name) understand that the massage I receive is provided for the basic purpose of relaxation and/or relief of muscular tension. 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.

24 Hour Cancellation Notice Policy

Please note that we have a **24hour notice of cancellation policy.** As a courtesy to your therapist as well as to other clients who may be able to receive a massage in your place; please call **978-658-7700** 24 hours in advance of your scheduled appointment if you need to cancel. While an occasional emergency situation is understandable, **multiple last minute cancelations will result in a charge of FULL payment equal to the amount of the massage.**

Please sign below. Your signature is your consent to treatment for therapeutic massage and that you agree to our 24 hour cancellation policy. You are also confirming that you have provided accurate and complete health information.

Signature of client ______________________________ Date ______________

Signature of Massage Therapist ______________________________ Date ______________