

**BAETENS CHIROPRACTIC CENTER
 MASSAGE & BODYWORK CLIENT INFORMATION**

Name: _____ Email Address: _____
 Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Referred By: _____
 In Case of Emergency: Name: _____ Phone: () _____

GENERAL & MEDICAL INFORMATION: IF YOU ANSWER YES TO ANY QUESTIONS BELOW, PLEASE EXPLAIN AS CLEARLY AS POSSIBLE

Have you ever had a professional massage/bodywork session? _____ Clinic? _____

Have you ever received Chiropractic care? _____ if so, are you currently under care? _____ Dr.'s Name _____

Yes	No		Yes	No	
___	___	Do you frequently suffer from stress?	___	___	Do you have cardiac or circulatory problems?
___	___	Do you experience frequent headaches?	___	___	Do you have numbness or stabbing pains anywhere?
___	___	Do you suffer from back pain?	___	___	Are you wearing contact lenses?
___	___	Are you epileptic?	___	___	Do you have tension or soreness in a specific area?
___	___	Are you diabetic?	___	___	Have you had any broken bones in the past 2 years?
___	___	Do you have high blood pressure?	___	___	Are you sensitive to touch/pressure in any area?
___	___	If yes to above, are you taking medication for this?	___	___	Any medical conditions I should be aware of?
___	___	Are you pregnant?			
___	___	Have you ever had surgery?			

Comments: _____

Please take a moment and carefully read the following information 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. 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/bodywork 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/bodyworkers 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(s) given should be construed as such. Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all question 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 forget to do so. It is also understood 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.

We have a 24 hour cancellation policy.

*** If your appointment is not cancelled 24 hours prior to your scheduled appointment, you will be responsible for full payment. ***

Signed: _____ Date: _____

Practitioner: _____ Date: _____