Mason Family Chiropractic & Wellness

Massage Case History

Date:_____

Name:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

E-mail address:_____

May we have your permission to e-mail you info on our events or special promotions?_____

Age:_____ Birth Date:_____ Gender: M F Marital: M S W D

Occupation:_____ Employer:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Referred by: _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto Accident___ Work Accident____ Other_____

Have you ever had the same or a similar condition? If yes, when and describe:_____

_____

Are you currently under a doctor's care? If yes, please explain:_____

_____

What makes the problem worse? _____

_____

What makes the problem better? _____

_____

PERSONAL PREFERENCES:

Have you ever had professional massage before? _____ How long ago? _____

Current issues you would like to address with massage: _____

_____

Are there any areas that should be avoided?_____

_____

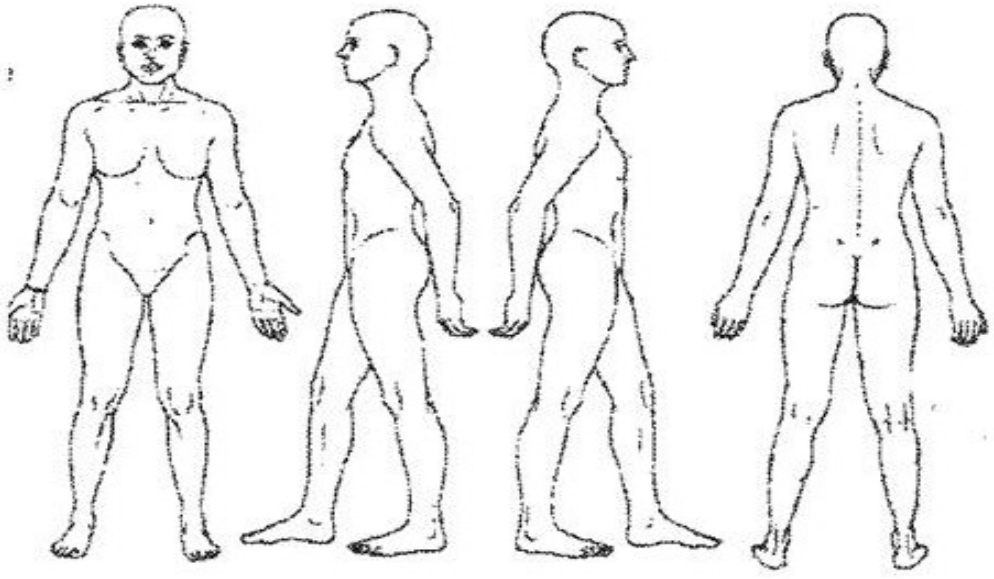
Adding Life to Your Years™
11580 Overlook Drive, Suite 200 ◆ Fishers, IN 46037
ph: 317.577.9558 ◆ fx: 317.577.9559
www.MasonFamilyChiro.com ◆ Info@MasonFamilyChiro.com

Do you have difficulty lying down on your front, side or back? _____

If yes, explain: _____

Do you have any allergies/sensitivity to any type of essential oils, lotions or any certain smells? _____

If yes, explain:_____



Please indicate on above image any areas that are currently bothering you:

MEDICAL HISTORY: Have you ever been diagnosed as having or have suffered from any of the following? Check all that apply.

__A Congenital Disease	__Osteoporosis	__Excessive bleeding	__Tumors
__Alcoholism	__Coughing Blood	__Gall Bladder	__Rheumatoid Arthritis
__Allergies	__Depression	__Heart Conditions	__Ruptures
__Blood Clot	__Diabetes	__High/Low Blood Pressure	__ Ulcers
__Broken or Fractured Bones	__Drug Addiction	__HIV Positive	__Seizures/Convulsions
__Cancer	__Eating Disorder	__Osteoarthritis	__ Skin Rashes
__Circulatory Problems	__Epilepsy	__Pace Maker	__ Strokes
			__ Headaches

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):

_____

Prescription medications: _____

_____

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No Show and Cancellation Policy

We ask that you arrive 10 minutes prior to your appointment. This allows you ample time to check-in, complete any paperwork and prepare for your treatment.

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

Please understand that your scheduled time may be a desired appointment time for other clients as well. In order to be courteous to them and your therapist, please give 24-hour notice of cancellations. Except for emergency situations, missing an appt without proper notification may result in a $25 fee assessed to your account.

All fees must be paid before another appt will be scheduled.

Late arrivals:

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Out of respect and consideration to your therapist and other customers, please plan accordingly to be on time.

Print Name: _____

Signature: _____ Date: _____

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Massage Patient Informed Consent

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or massage strokes may be adjusted to my level of comfort. It is common after a massage therapy session to experience some residual soreness, tightness, or mild discomfort for up to 2-3 days after treatment; you may also experience an increase in headaches although this is also usually mild & goes away within the same time frame. If I experience any prolonged adverse effects from a massage, I will contact Dr. Mason or my primary care doctor as soon as possible. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known conditions & answered all questions honestly. I agree to keep the practitioner updated 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 understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Chiropractor &/or Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Turn cell phones off or to vibrate during your session.

I understand the therapist's policies and agree to abide by them. Understanding all of this, I give my consent to receive care.

Print Name: _____

Signature: _____ Date: _____

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Minor Release Form

All persons under the age of 18 are required to have a parent or guardian Fill out the below:

By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) at out facility. You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). We may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor.

You also agree that you have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

PLEASE PRINT CLEARLY:

I _____, certify that I am the parent or legal guardian of _____, who is _____ years of age. I have informed the therapist of all relevant medical history and concerns. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and it is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

Print Name: _____

Signature: _____ Date: _____

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