Are you sensitive to pressure or touch in any areas? _____

Have you ever had surgery?_____

Other medical conditions or are you taking medications I should know about? _____

Comments: _____

_____

Hot Stone Massage Therapy:

The following conditions are not reccommended to recieve Hot Stone treatment as is could cause the condition to worsen:

Blood clots/prone to blood clots
Bruise easily
Cancer, chemotherapy or radiation treatments
Depressed immune system (lupus, HIV/AIDS, cancer, Epstein Barr, mononucleosis, etc)
Diabetes
Fever
Heart problems
Heat sensitivity
High blood pressure
Inflamed skin conditions
Nerve trauma
Neuropathy
Open wounds or sores
Peripheral vascular disorder
Pregnancy
Recent sugery
Taking medications that have side effects to heat.
Varicose veins

Fitzpatrick Classification Scale: (please circle the skin type that applies)

Skin Type	Skin Color	Characteristics
I	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	Very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

I understand that the massage 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 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 of which I am aware. I understand that massage practitioners 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 should be construed as such because massage should not be performed under certain medical conditions. I affirm that I have stated all of my known medical conditions and answered all questions 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 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.

Client signature _____ Date _____

Practitioner signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage/bodywork and somatic therapy techniques to my child or dependent as they deem necessary.

Parent/Guardian Signature _____

Davis Chiropractic

Massage Client Information

Name_____ Phone (____)-_____ DOB _____

Address _____ City_____ State____ Zip_____

E-mail _____Referred by _____

In case of emergency: _____ Phone (____)_____

Occupation _____ Physician_____

Health Insurance Carrier _____

Please take a moment to 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 care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? YES NO If yes, how recently? _____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? (circle one) **light medium firm**

Do you have tension or soreness in a specific area?_____ Please specify_____

Approximate date of your last spinal exam?_____

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN AS CLEARLY AS POSSIBLE

Please mark yes for all that apply to you :

Do you frequently suffer from stress? ___

Do you bruise easily? ____

Do you have diabetes? ____

Any broken bones in the past 2 years?___

Do you experience frequent headaches? ____

Any injuries in the past 2 years? ___

Are you pregnant? ____

Are you wearing dentures? ___

Do you suffer from arthritis? ___

Do you have high blood pressure medications? __

Are you wearing contact lenses? ___

Do you suffer from epilepsy or seizures? ___

Do you suffer from joint swelling? ___

Do you have varicose veins?___

Do you have osteoporosis? ___

Do you have allergies?___

Do you suffer from back pain? _____

Do you have cardiac or circulatory problems? _____

Do you have numbness or stabbing pains?____

Are you currently receiving chiropractic care?_____