KEYSTONE CHIROPRACTIC, LLC

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keystonechiropracticpdx.com

Massage Questionnaire

In order to maximize the effectiveness and safety of our session together, we ask that you take the time to fill out this confidential questionnaire carefully.

Name: _____ D.O.B: _____ Date: _____

What brings you here today? _____

_____

Are you experiencing any of the following? ☐ Pain ☐ Stiffness ☐ Tension ☐ Numbness ☐ Tingling
What areas of the body?: ☐Neck ☐ Upper Back/Shoulders ☐ Low Back
☐ Other(s): _____

Is there any area where you would like extra time spent? ☐ Neck ☐ Upper Back/Shoulders ☐ Low Back
☐ Other(s): _____

Have you previously had a professional massage? ☐ Yes ☐ No If yes, with whom and when was the last date you were treated? _____ Did it help? ☐ Yes ☐ No

How is most of your day spent? ☐ Standing ☐ Sitting ☐ Driving ☐ Walking ☐ Other: _____
Do you participate in any sports? ☐ Running/walking ☐ Golf ☐ Baseball/Softball ☐ Basketball ☐ Soccer ☐ Football
☐ Other(s): _____ ☐ None

Medical History

Please indicate below any significant medical problems, as such conditions can influence they type and/or depth of work done in any given area. Thank you.

Allergies: ☐ Seasonal ☐ Skin allergies (eg; latex) ☐ Other, please list: _____
Skin condition: ☐ Acne ☐ Rash ☐ Fungal infections ☐Skin cancer ☐ Other: _____
Lymphatic condition: ☐ Swollen glands ☐ Lymphoma ☐ Lymphedema ☐ Other: _____
Recent injury or accident: ☐ Auto ☐ Work ☐ Slip & fall ☐ Other: _____
Circulatory condition: ☐ Heart disease ☐ Varicose veins ☐ Arrhythmia ☐ Phlebitis ☐ Other: _____
Neurological condition: ☐ Sciatica ☐ Stroke ☐ Epilepsy ☐ Other: _____
Joint problems, pain, or stiffness: ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Gout ☐ Hypermobile joints
☐ Sacroiliac problems ☐ Other: _____
Bone conditions: ☐ Osteoporosis ☐ Previous fracture ☐ Cancer ☐ Other: _____
Headaches: ☐ Migraines ☐ PMS ☐ Tension ☐ Cluster ☐ Other: _____
Emotional difficulties: ☐ Depression ☐ Anxiety ☐ PTSD ☐ Other: _____
Previous surgery? Please state type and date: _____
List any medication(s) and the dosage you are currently taking: _____

_____

Tobacco use? ☐ Yes ☐ No If yes, what type? ☐ Smoking (packs per day? _____) ☐ Chewing (cans per week? _____)

Can you lie comfortably on your stomach? ☐ Yes ☐ No On your back? ☐ Yes ☐ No On your side? ☐ Yes ☐ No
Are you pregnant? ☐Yes ☐ No If yes, what is the estimated due date? _____

Name of current primary care provider: _____
Do we have permission to contact him/her should the need arise? ☐ Yes ☐ No

Patient signature: _____ LMT signature: _____
Date: _____ Date: _____

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Massage Therapy Consent Form

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 the session, 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. 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 massage therapist updated as to any changes in my medical profile during today's and all future sessions, and understand that there shall be no liability on the massage therapist's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of session.

I also understand that the license massage therapists reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. If I have a certificate for massage, I understand I must present it before the massage is rendered.

Client Signature: _____ Date: _____

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Massage Cancellation Policy

I understand that 24 hours is required to cancel a massage appointment at Keystone Chiropractic clinic.

If as least a 24 hour notice is not given or if I do not show up for my appointment, a $35 personal fee is due on my next visit. This fee is my direct responsibility and cannot be billed to an insurance carrier.

_____

Patient's Signature

_____

Date