RYKEN

## Massage Client Information

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____

Email:_____ Occupation:_____

Emergency contact:_____ Phone:_____

How did you hear about our office? _____

## Health information

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

Please check any condition listed below that applies to you:

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

( ) join disorder/rheumatoid arthritis/osteoarthritis/tendonitis

( ) pregnancy- if yes, how many months? _____

Please explain any condition that you listed bove:_____

Have you had professional massage before? Yes No If yes, how often? _____

Do you have difficulty lying on your back, front or side? Yes No If yes, please explain: _____

Do you have any allergies to oils, lotions or ointments? Yes No If yes, please explain: _____

Do you have sensitive skin? Yes No

Are you wearing contact lenses ( ) dentures ( ) hearing aid ( ) ?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe: _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe: _____

RYKEN CHIROPRACTIC & WELLNESS CENTER

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 ( )

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

If yes, please identify: _____

Do you have any goals in mind for this massage session? Yes No

If yes, please explain: _____

Are you currently under any medical supervision? Yes No

If yes, please explain: _____

Do you see a chiropractor? Yes No If yes, how often? _____

Are you currently taking any medication? Yes No

If yes, please list: _____

Is there anything 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
- Informed written consent must be provided by parent or legal guardian for any client under the age of 18

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**Cancellation Policy:** Kindly give 24 hour notice to change or cancel your appointment to avoid any cancellation fees.

**Late Arrival Policy:** You will be responsible for full payment for the time as scheduled. If you arrive late, your time may be shortened at your practitioner's discretion, so that time for the next client may start on time.

**Disclaimer/Release:**

I, _____(print name) 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 and that I should see a physician, chiropractor, or other qualified medical specialist for any medical 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 during session given should be constructed 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 that my practitioner, Ryken Chiropractic & Wellness Center, and its staff shall not be liable should any injury occur, due to my withholding information, or for any other reason. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability to the therapist's part should I fail to do so. Information exchanged during any therapeutic session is educational in nature and is intended to help me become more familiar and conscious of my own health. I acknowledge that this is a professional environment and the practitioner has the right to terminate the session at any time for any inappropriate behavior and payment will be due for the full session

Signature:_____ Date: _____.

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