Horn FAMILY CHIROPRACTIC

Massage Screening Questionnaire

Name_____ DOB_____ Date_____

Home#(___)_____ Work#(___)_____ Cell#(___)_____

Best time(s) to call_____ Email_____

Address_____

Occupation_____ Work Hours_____

Description of what you do at work_____

Purpose of Massage: Relaxation or addressing an injury_____

What type of care have you received for the health challenge you are currently experiencing. Please circle:
Massage Therapy Chiropractic Acupuncturist Contact Reflexologist Medical Doctor Other

What response did you have from the previous treatment?_____

Description of injury:_____

What makes it worse?_____

What questions or concerns might you have?_____

Have you previously had a massage? Yes____ No____
When?_____ Frequency_____ Modality used_____

If you answer "yes" to any of the following questions, please explain as clearly as possible:

Y N Do you frequently suffer from stress?
Y N Do you have diabetes?
Y N Have you experienced frequent headaches?
Y N Are you pregnant? How many weeks?____
Y N Do you suffer from arthritis?
Y N Do you have high blood pressure?
Y N If "yes" to previous questions, are you taking medication for this?
List medication_____
Y N Do you suffer from epilepsy or seizures?
Y N Do you suffer from joint swelling?
Y N Do you have varicose veins?
Y N Do you have any contagious diseases, including but not limited to skin diseases?
If yes, please explain._____
Y N Do you have osteoporosis?
Y N Do you have any allergies including but not limited to any oils or lotions?
If yes, please list._____
Y N Do you bruise easily?

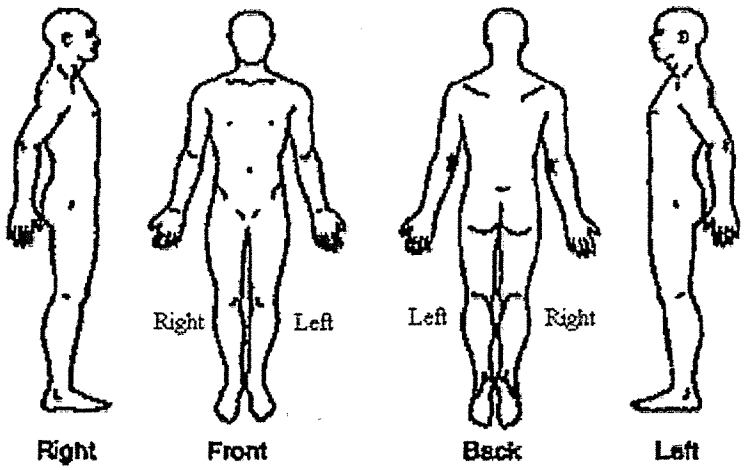
Y N Have you been in an accident or suffered any injuries in the past two years?
Please explain_____
Y N Do you have tension or soreness in a specific area? Please specify:
_____
Y N Do you have cardiac or circulatory problems?
Y N Do you suffer from back pain?
Y N Do you have numbness or stabbing pains anywhere? Where?_____
Y N Are you sensitive to touch or pressure in any area? Where?_____
Y N Have you ever had surgery? If "yes" please specify:_____
Y N Do you have any medical condition or are you taking any medications that I should know about? If "yes" please specify:
_____
Y N Do you wear hearing aids?

Comments: _____

_____

_____

On the diagram, please indicate the area you would like focused on and/or where you are experiencing pain:



What are your expectations/goals that you would like to achieve through massage therapy?

_____

_____

_____

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 during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. **Initials:** _____

I acknowledge that should I be late for my appointment the therapist has the right to alter the length of my massage to suit the needs of the office schedule. 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 in full of the scheduled appointment. **Initials:** _____

I certify that I am not under the influence of any alcohol, drugs or narcotics and understand that I will not receive any treatment if I am under the influence of such substances. I further acknowledge that if I am found to be under the influence that my session will be terminated and I will be liable for payment in full of the schedule appointment. **Initials:** _____

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 qualified medical specialist for any mental or physical ailment of which I am aware. I understand 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on TRHJLD, LLC d/b/a Horn Family Chiropractic or the massage therapist's part should I fail to do so. **Initials:** _____

Client Signature:_____ Date:_____

Therapists Signature:_____ Date:_____

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

Signature of Parent or Guardian_____ Date:_____

Horn FAMILY CHIROPRACTIC

Massage Therapy Policies & Procedures

To achieve a soothing, healing environment, and enhanced massage experience, we kindly request our guests observe our Massage Policies.

Appointments:

Due to the demand of our unique services, we require that you schedule an appointment in advance for all massage services. A Visa, MasterCard or Discover credit card is required to hold your reservation(s).

Arrival Time:

To make the most of your massage experience, please arrive 15 minutes prior to your scheduled appointment. This will allow all necessary paperwork to be completed and ensure you receive a full massage service.

Late Arrivals:

In the event that you are running late, we will endeavor to conduct your full massage, however, please note that the massage may need to be shortened if the therapist has another booking immediately afterwards. HFC reserves the right to charge 100% of the service price when accommodating late clients. The reservation of an appointment indicates that HFC has reserved the service time for you and therefore has had to decline other customer business for that particular service at the office.

Cancellations:

Please note we require at least 12 hours notice to cancel any appointment. Once an appointment is booked—unless we hear otherwise—we'll expect you to be there. We reserve the right to charge your credit card for the full service cost for all "No Shows" and appointment cancellations/rescheduling done in less than the time required by this Cancellation Policy.

Payment:

We gladly accept Cash, Check, Visa, MasterCard and Discover cards. Prices are subject to change without notice. We charge $25 for a returned check.

Gift Certificates:

Gift Certificates are always welcome and can be used towards your massage. Your Gift Certificate should be presented at check out, otherwise you will be responsible for all massage services incurred at HFC.

Feedback:

Although we do our best to anticipate your needs, we appreciate that a massage is a very individual experience. Please let your therapist know if there is any way to improve your massage or comfort. For example: deeper or lighter massage pressure, an extra towel, sound or lighting levels, etc. We truly appreciate your feedback.

I have reviewed the Massage Therapy Policies & Procedures of Horn Family Chiropractic. By signing below I am acknowledging that I understand and agree to the above policies.

Signature_____ **Date**_____

For Therapist Use Only

Client Name:_____ Date:_____

Massage Therapist Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Communication with Client:

- ☐ Draping
- ☐ Oils/lotions/allergies
- ☐ Fees/payment
- ☐ Clothing
- ☐ Confidentiality
- ☐ Late arrival policy
- ☐ Special needs/other