Date:_____

Portage Chiropractic & WELLNESS CENTER

Erika Christoph, LMT
609 E. Centre, Portage, MI 49002
269.329.1660

Name: _____ Date of Birth: _____ Gender: _____

Street Address: _____ City:_____ State:_____ Zip Code:_____

Phone: _____Email:_____

Occupation: _____Referred by: _____

Emergency contact: _____Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? **Yes** ☐ **No** ☐

Do you have a physician referral/prescription? **Yes** ☐ **No** ☐

Are you seeking insurance reimbursement? **Yes** ☐ **No** ☐

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage before? **Yes** ☐ **No** ☐ How recently? _____

What are your goals/expected outcomes for receiving massage? _____

_____

How do you feel today? List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):_____

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?

Yes ☐ **No** ☐ **Explain**: _____

_____

List the medications you currently take: _____

_____

Are you wearing contacts? **Yes** ☐ **No** ☐

Are you wearing dentures? **Yes** ☐ **No** ☐

Are you wearing a hairpiece? **Yes** ☐ **No** ☐

Are you pregnant? **Yes**☐ **No** ☐

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

_____

Patient's Full Name: _____ Date: _____

Circle any of the following health conditions that you currently have (Please answer honestly, as massage may not be indicated for the above conditions):

Blood clots **Infections** **Congestive heart failure** **Contagious diseases** **Pitted edema**

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current ____ Past ____ Muscle or joint pain

Current ____ Past ____ Muscle or joint stiffness

Current ____ Past ____ Numbness or tingling

Current ____ Past ____ Swelling

Current ____ Past ____ Bruise easily

Current ____ Past ____ Sensitive to touch/pressure

Current ____ Past ____ High/Low blood pressure

Current ____ Past ____ Stroke, heart attack

Current ____ Past ____ Varicose Veins

Current ____ Past ____ Shortness of breath, asthma

Current ____ Past ____ Cancer

Current ____ Past ____ Neurological

Current ____ Past ____ Epilepsy, seizures

Current ____ Past ____ Headaches, Migraines

Current ____ Past ____ Dizziness, ringing in the ears

Current ____ Past ____ Digestive conditions

Current ____ Past ____ Gas, bloating, constipation

Current ____ Past ____ Kidney disease, infection

Current ____ Past ____ Arthritis

Current ____ Past ____ Osteoporosis

Current ____ Past ____ Scoliosis

Current ____ Past ____ Broken bones

Current ____ Past ____ Allergies

Current ____ Past ____ Diabetes

Current ____ Past ____ Endocrine/thyroid conditions

Current ____ Past ____ Depression, anxiety

Current ____ Past ____ Memory Loss, confusion, easily overwhelmed

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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/bodywork 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 given should be construed as such. Because massage/bodywork 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 practitioner updated as 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 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ **Date:** _____

Parent or Guardian Signature (in case of a minor): _____ **Date:** _____