Touch of Health Chiropractic:
A Creating Wellness
Center

MASSAGE INTAKE

Name: _____ Date of Birth: _____ Date: _____

Street Address: _____ Referred By: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Name of Spouse/Significant Other: _____ Marital Status: [Single] [Married]

Emergency Contact Name & Phone: _____

Are you under chiropractic care here? [No] [Yes, Dr. Melissa Tosczak] [Yes, Dr. Kris Tosczak]

Have you ever had a professional massage? [No] [Yes}

What are your goals for your session? _____

Present Symptoms: _____

_____

Are you under medical/therapeutic treatment? [No] [Yes] – What? _____

_____

Please list medical provider's name & phone: _____

List any medications (including aspirin) and nutritional supplements you are taking:_____

_____

Specify any allergies: _____

Please list any comments regarding your health or any emotional stresses you may be dealing with: _____

_____

Do you have any communicable or infectious conditions? [No] [Yes] – What? _____

_____

Are there any injured areas or conditions, such as bruises, cuts, sores, abnormal blood pressure, blood clots or cancer, that may be aggravated by massage? [No] [Yes] – What? _____

_____

Do you like aromatherapy (*i.e. scented oils*)? [No] [Yes] _____

Do you have any allergies to fragrances of flowers? [No] [Yes] _____

In undertaking a massage at Touch of Health Chiropractic, I _____

Agree that: *The purpose of the massage is to provide stress relief, pain control and relax. The therapist will not treat, prescribe or diagnose an illness, disease or any other physical or mental disorder. Nothing said in the course of a massage session should be misconstrued to be such. I understand that a massage involves having my body touched. I hereby authorize the therapist to perform massage. I understand that any relief of physical or emotional symptoms is the product of processes, which reside within me. The power to heal comes from within. I understand that I am responsible for my emotions, feelings, body and belongings and the therapist is responsible only for giving a massage. Control of the session is always mine and I can stop it at any time. In the spirit of this understanding, I agree to hold Touch of Health Chiropractic and its employees blameless from any problem which may arise as a result of my massage.*

I have read, understand, and agree to the above.

Signature: _____ Date: _____

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Massage Informed Consent Agreement

By signing, client acknowledges having read and agreed to all terms of receiving bodywork. Any questions should be asked prior to receiving massage. Client also releases Therapist and Touch of Health Chiropractic from responsibility for any conditions that may arise during or after receiving massage.
Specialize: (depending on Therapist) Sweedish Massage, Deep Tissue Massage, Hot Stone Massage, Sports Massage, Reflexology, Prenatal Massage and Postpartum Massage. *Specific benefits and contraindications vary by modality.
General Benefits: Increases in circulation, waste removal, range of motion, flexibility, energy, heart rate, body temperature, immunity, body awareness and relaxation; decreases in discomfort, fatigue, tension, and stress levels.
General Contraindications: Medical emergencies (shock, hemorrhage, seizure, poisoning, etc), high fever (102 degrees F), highly-metastatic cancer, intoxication, pain medications, or extreme fatigue (mental or physical).
Work with Limitations: Open wounds, burns, inflammation, fractures, contagious or irritable skin conditions, recent surgery, pregnancy, recent injury, prescription medication, physicians' restrictions, or any immune system illness.
**Any client under physicians' care must notify the therapist of condition and changes. Working without physician approval may be detrimental to the physical well being of the client.
Rates: $90/hour and $125/90 minutes – Base rates (specialties have additional costs). Payment is due when service is received. Advanced payment will be accepted. Cash, checks, and credit cards accepted. A fee of $20 will be charged for any returned check. Only two returned checks will be allowed before only cash is acceptable. Specials and packages are available. Sessions will be by appointment only with weekday and weekend availability.
Confidentiality: All information/conversation exchanged during a treatment session or about a treatment session remains confidential for the safety and well being of the client and therapist.

General Etiquette:

- **Late clients will have a shortened treatment at the same rate of a full session.**
- **No shows will be charged for a full session**.
- **Cancellations 12 hours prior to session will not be charged. After three cancellations, there will be a charge for a full treatment session.**
- **Intoxication (any alcohol consumption) will not be permitted. There are many negative effects on the body when combining massage with alcohol. Client will be asked to leave and charged full price for a treatment session**.

Recommendations: Do not eat 90 minutes before a session. Food fresh in the system may have an adverse effect on the client. For shiatsu treatments, plan on having time after session for low-key activity or sleep. Contact lenses may become "dry" during treatment session. Bringing a case is suggested.

Right of Refusal: Therapist and client both reserve the right to end a treatment session at any time for any reason. Therapist will fill out a disclosure statement to inform client why treatment session is ending. Client does not need to give any reason for ending a treatment session.
Sexual innuendos, language and/or behavior will not be tolerated. Session will end immediately and client will be charged full price.

Client's Signature_____ Date _____