Patient Data

First Name: ________________________ **Middle Initial:** ______ **Last Name:** _____________________________

Address Line : ____

City: __________________________________ **State:** ___________________ **Zip Code:** ___________________

Home Phone: (______)_________-______________ **Cell Phone:** (______)_________-______________
Email: ____ **Date of Birth:** ______/______/_________
(Used for Internal Promotions and Specials Only) **Sex:** ☐Male ☐Female

Emergency Contact

Contact Name:_____________________________________**Contact Phone:** (______) _______-__________

How did you hear about our clinic? Or who referred you?

❑ Family member ❑ Attorney ❑ Internet web site ❑ Sign on building
❑ Friend ❑ Employer ❑ Post Card ❑ Phone Book
❑ Living Social Website ❑ Search Engine ❑ Advantage Coupon ❑ Direct mail ad

Allergies:

❑ Contact Dermatitis ❑ Essential Oils ❑ Aromatherapy Oils ❑ ___________________
❑ Nut Allergy ❑ Peanut ❑ Latex ❑ ___________________

Social History:

❑ Drink alcohol often ❑ Caffeine used often ❑ Exercise often ❑ Experience stress often
❑ Drink alcohol occasionally ❑ Caffeine used occasionally ❑ Exercise occasionally ❑ Experience stress occasionally
❑ Exercise not at all ❑ Experience Stress Never

Personal History: Do you currently or have you previously experienced the following?

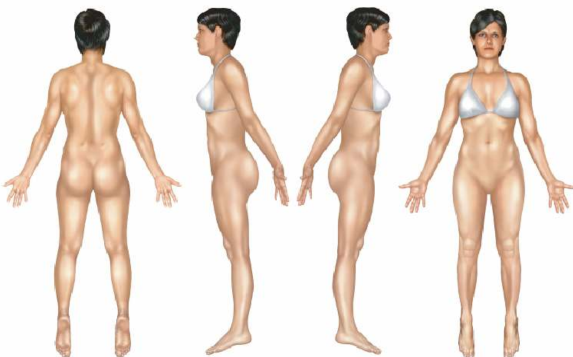
❑ Pregnant ________ Months ❑ Previous Pregnancy ❑ Decrease Sensation ❑ Dizziness
❑ Poor Circulation ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Heart Disease
❑ Stroke ❑ HIV/AIDS ❑ Diabetes ❑ Hernia
❑ Epilepsy ❑ Depression ❑ Anxiety ❑ Carpal Tunnel
❑ Arthritis ❑ Skin Lesions/Rashes ❑ Eczema/Psoriasis ❑ Cancer
❑ Surgeries ❑ Traumas ❑ Auto/Work Accident ❑ Other___________________

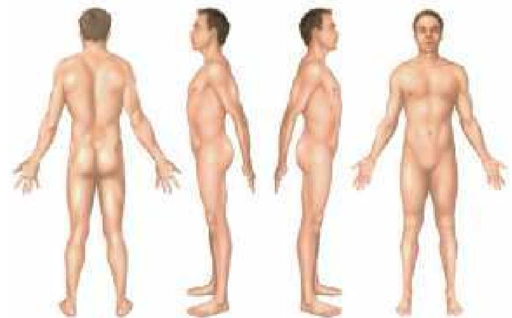
Medications: Please list any Over the Counter or RX Drugs: ____

____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**





Reason for visit:____

____

Do you have clearance from your primary Doctor? (applies to certain medical conditions) ☐ Yes ☐ No ☐ Does Not Apply

Schrage Chiropractic
Acupuncture | Massage
1710 N 144th St, Suite B
Omaha NE 68154
(402) 885-8783

MASSAGE THERAPY INFORMED CONSENT

I,____, am voluntarily seeking therapeutic massage of my own accord for the purposes that massage is intended, such as relaxation, mental wellness, relief of tension of sore muscles, improved circulation and/or range of motion.

Overview of possible side-effects:

Some temporary side effects of massage therapy may include:

- ☐ Stiffness, pain, discomfort, swelling, and/or soreness.
- ☐ A sensitivity or allergy to massage oils.
- ☐ Headaches. (In result of increased blood flow & especially if not drinking enough water afterwards)
- ☐ Flu like symptoms. (In result of toxins being flushed out).

After the massage, it is recommended to drink more water than usual, in order to help relieve side-effects.

Scope, Draping and Sensitive Areas

Appropriate draping will be used during each session. If I get too cool or warm or if I feel uncomfortable during the massage, I will let my therapist know and they will adjust the draping and room temperature accordingly.

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. The general guideline is that in the scale of 0 to 10, where 0 is no sensation, 10 is an excruciating pain, and 7 is the borderline between a 'good pain' and 'begin-to-hurt pain', then I will inform the therapist when reaching 7 in the scale.

Disclaimers

I understand that massage or 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 also understand that the therapist is 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.

I 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.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, including any communicable disease, that I have disclosed all medications that I am currently taking, that I have stated any known allergies and that I 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 the therapist's part should I fail to do so.

Signature: ____Date: ______________

Consent to Treatment of Minor:

By my signature below, I hereby authorize Licensed Massage Therapist at Schrage Chiropractic to administer massage and bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian:__________________________________Date: ______________

Name of Parent or Guardian:____