

Bartz Chiropractic
814 Pine Island Road, Suite #306
Cape Coral, FL 33991

MASSAGE THERAPY CONSENT

Date _____

Name _____
First Middle Last

Primary Care Physician _____

Address _____

Employer _____

City _____ State _____ Zip _____

Heard about us _____

Soc Sec # _____ Home Phone _____

Spouse's Name _____

Work Phone _____ Marital Status: M S W D

Spouse's Employer _____

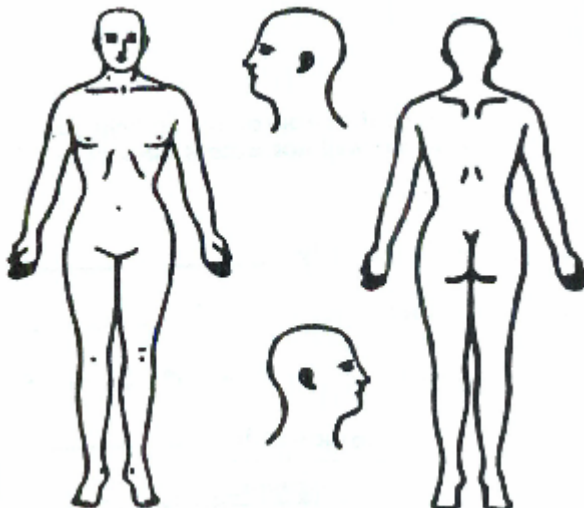
Birthdate _____ Age _____ Gender: M F # of Children _____

Spouse's Work Phone _____

HEALTH INFORMATION

Reason for seeking masage?					
How long have you had this condition?				Have you had this or similar conditions in the past?	
				Yes	No
Have you had previous massage therapy?		Yes	No	Is condition getting progressively worse?	
				Yes	No
		Constant		Comes and goes	
Other Drs / LMT's who treated this condition	Name			Address	
What activities aggravate your condition?					
Is this condition interfering with your:		Work	Sleep	Daily Routine	Other
List surgical operations and year	Year	Operation			
Prescriptions you now take	Dosage	Prescription		Reason	

Please mark your areas of pain on the figures below.



Date of last physical exam _____

Height _____ Weight _____

Have you ever suffered from:

- Dizziness
- Backaches
- Heart trouble
- Diabetes
- Arthritis
- Headaches
- Asthma
- Neuritis
- Digestive disorders
- Nervousness
- Neck Pain
- Allergy / Adverse Reaction
- Other _____

Please take a moment to carefully read the following information:

I hereby request and consent to massage therapy and any other therapies that fall under the scope of practice of the professional treating me who are either employed by or contracted by Bartz Chiropractic, LLC.

I understand that I will be receiving massage therapy for therapeutic reason. I understand and am informed that there are some risks to treatment, including, but not limited to, soreness, bruises, inflammatory pain. I do not expect the therapist to be able to anticipate or explain all risks and complications, and wish to rely on the therapist to exercise reasonable skill during the course of treatment.

I understand that massage therapy may involve some undressing. I understand that at all times the therapist will abide by my wishes with regards to my comfort level of undress. I also understand that I can request an area not to be treated or exposed.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions regarding its content, and by signing below I agree to the above named procedures. I intend this consent form to cover treatment for my present condition, as well as all future conditions for which I seek treatment.

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 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 understand that massage therapists are not qualified to perform skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be constructed as such. 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 the therapists 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 termination of the session, and I will be liable for payment of the scheduled appointment.

Patient's Signature _____ Date _____