CARE CHIROPRACTIC BODY & WELLNESS CENTER
3390 Coachman Road, #214, Eagan, MN 55121
Care at the Metropolitan, 7300 France Avenue South, Suite 300, Edina, MN 55435

Massage Therapy Client Information and Release Form

Name: _____ Date of Birth: _____

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

Home#: _____ Work #: _____ Cell #: _____

Email Address:_____

Emergency Contact: _____ Phone: _____

How did you hear about our clinic? _____

General Medical Information

Yes	No		(Please explain any "Yes" answers)
❑	❑	Have you ever had a therapeutic massage?	_____
❑	❑	Do you experience migraine headaches?	_____
❑	❑	Are you wearing contact lenses?	_____
❑	❑	Are you a diabetic (insulin dependent)?	_____
❑	❑	Do you have high blood pressure?	_____
❑	❑	Are you epileptic?	_____
❑	❑	Are you under treatment for a heart condition?	_____
❑	❑	Do you have phlebitis or varicose veins?	_____
❑	❑	Are you pregnant? If so, due date:	_____
❑	❑	Have you ever had cancer?	_____
❑	❑	Do you have any skin disorders?	_____
❑	❑	Do you have any metal prostheses or implants?	_____
❑	❑	Are you currently taking any medications? *(Please list)*	_____
❑	❑	Have you had surgery within the last one year? *(Please list)*	_____
❑	❑	Do you have any stress-related pain? Where:	_____
❑	❑	Is there anything else you'd like the massage therapist to know?	_____

Any questions marked with a "yes" will be discussed prior to your therapy session.

Please take a moment to read and sign the following statement. A copy will be given to you at your request.

I, _____, understand that the massage/bodywork I receive at Care Chiropractic Body Wellness Center is provided for the basic purpose of relaxation, Stress reduction, and relief of muscular tension, unless specifying otherwise by a referring physician. If I experience pain or discomfort during this session, I agree it is my responsibility to inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage therapists/body workers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any mental illness, and that nothing in the course of the session should be construed as such. I understand I should see a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment of which I am aware.

Because massage/bodywork should not be done 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 there shall be no liability on the practitioner's part if I forget to do so.

It is also understood 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 "full" scheduled appointment.

I also agree to give 24 hours notice should I need to cancel or change my appointment. **If I fail to give 24-hour notice, I will be responsible for a $25.00 service charge. This charge may be waived in the** event of illness, family emergency, or unavoidable circumstances. Questions should be directed to the Office Manager.

Complementary and Alternative Health Care Client Bill of Rights

Care Chiropractic Body Wellness Center is providing every massage client with a *Client Bill of Rights* as required by law in the state of Minnesota.

The State of Minnesota has not adopted any educational training standards for unlicensed complimentary and alternative health care practitioners. Under the Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments.

Any client who has any concerns about their care at Care Chiropractic Body Wellness Center may bring these concerns to Dr. James J. Ackelson. Concerns may also be directed to the office of unlicensed complimentary and alternative health care practice. Metro Square Building 121 East Seventh Place, suite 400 Saint Paul, MN 55101.

All records of visits are kept in confidence and will only be released with the client's written authorization. A client always is provided access to his or her own records.

Upon my request a copy of this information will be provided to me. I understand that it is my responsibility to be familiar with the contents and discuss any questions I have with the massage therapist, or Dr. James Ackelson.

My signature validates that all of the information given is accurate and I have read and understand the information given on this form.

_____ _____

Client Signature Date

_____ _____

Guardian Signature Authorizing Care to Minor Child Date