PARRISH FAMILY CHIROPRACTIC

JOSHUA S. PARRISH, DC ~ SELENA PARRISH, DC

PFC

Massage Therapy Intake Form

Name_____DOB_____

Address_____

City_____State_____Zip_____

Phone_____Email_____

Please indicate all that apply.

- Allergies_____
- Blood Pressure Conditions_____
- Chronic Pain_____
- Diabetes_____
- Headaches_____
- Heart Problems_____
- History of Strokes_____
- Injuries_____
- Surgeries_____
- Medications_____

*Pregnancy_____

*Cancer_____

Desired Massage Pressure (Please Circle One): Light Medium Deep

Are you comfortable having therapeutic massage in the following areas?

Gluteal region: Y☐ N☐ Scalp: Y☐ N☐ Abdomen: Y☐ N☐ Feet: Y☐ N☐

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and to inform the therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the pressure. Modest draping will be used during all sessions. You understand and voluntarily accept any risks which have been explained to you, from any liability, any injury, including, without limitation, personal bodily or mental injury, economic loss or any damages to you resulting therefrom. You further hereby release all of the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation, or specific sensitivity, or your failure to disclose any discomfort during the session. The therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session due to health-related concerns. In this event you may be required to provide the therapist with a physician's medical release prior to continuing treatment. If you have any questions, comments or concerns, please bring it to the attention of the therapist immediately. If during the session you feel uncomfortable, simply ask the therapist to end the session. The undersigned acknowledges that he/she has read this agreement.

Signature_____ **Date**_____

Consent to Treat Minor

If signing for a minor patient, I hereby state that my rights have not been revoked by court of law.

Signature_____**Date**_____

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