

# MASSAGE THERAPY REGISTRATION AND HISTORY

## 1 CLIENT INFORMATION

Date \_\_\_\_\_

Client \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is client covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## 3 PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 5 CLIENT CONDITION

When did your symptoms appear? \_\_\_\_\_

What treatment have you already received for your condition?

Medication  Surgery  Physical Therapy  Chiropractic Care  None  Other \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down

Name and address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

# 6

## MESSAGE HISTORY

Have you ever received a professional massage?  Yes  No

Why did you come for our service?  Relaxation  Pain  Therapy  Other \_\_\_\_\_

What results would you like to achieve? \_\_\_\_\_

Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you prefer not to be massaged. \_\_\_\_\_

# 7

## HEALTH HISTORY

Please check  conditions or symptoms you currently have or have had in the past:

- |                                               |                                         |                                              |                                               |                                          |
|-----------------------------------------------|-----------------------------------------|----------------------------------------------|-----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Anorexia             | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Jaw Pain/TMJ        | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis         | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Lymphedema          | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Fractures      | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whiplash        |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Head Injuries  | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Sinus Problems       | _____                                    |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Stroke               | _____                                    |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Hernia         | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tendonitis           | _____                                    |
| <input type="checkbox"/> Bulimia              | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pinched Nerve       | <input type="checkbox"/> Thyroid Problems     | _____                                    |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Herpes         |                                              |                                               | _____                                    |
| <input type="checkbox"/> Chemical Dependency  |                                         |                                              |                                               | _____                                    |

### MEDICATIONS

Medication	Taking For
_____	_____
_____	_____

### ALLERGIES

\_\_\_\_\_

\_\_\_\_\_

### VITAMINS/HERBS/MINERALS

\_\_\_\_\_

\_\_\_\_\_

### EXERCISE

- None  Daily
- Moderate  Heavy

### WORK ACTIVITY

- Sitting  Light Labor
- Standing  Heavy Labor

### LIFESTYLE

- Smoking Packs/Day \_\_\_\_\_  Coffee/Caffeine Cups/Day \_\_\_\_\_
- Alcohol Drinks/Week \_\_\_\_\_  High Stress Level Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Please list any medical conditions, surgeries, accidents, and bone, joint or muscle diseases or injuries not specified above.

\_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

# 8

## AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## **BENEFITS OF MASSAGE**

MASSAGE CAN BENEFIT THOSE WHO SUFFER FROM STRESS IN THEIR LIVES, PEOPLE WITH BACK OR NECK PAIN, INJURIES OR THOSE WHO EXERCISE FREQUENTLY. IN THE CASE OF STRESS RELIEF, OUR MENTAL TENSIONS QUICKLY BECOME MUSCLE TENSIONS. MASSAGE CAN COUNTERACT THAT TENSION AND RELAX YOU. HOW? THROUGH AN INDIRECT FEEDBACK SYSTEM. MUSCLE TENSION IS CONTROLLED BY THE BRAIN, CONSISTENTLY REFLECTING YOUR PSYCHOLOGICAL STATE. THE SOOTHING PHYSICAL SENSATIONS PRODUCED BY MASSAGE FEED BACK TO THE BRAIN AND REDUCE ANXIETY. THE BRAIN IN TURN TELLS ALL THE MUSCLES TO UNWIND. THAT'S WHY MASSAGE IN ONE AREA CAN PRODUCE A BODY-WIDE FEELING OF RELAXATION.

BACK AND NECK PAIN ARE THE MOST COMMON SPECIFIC COMPLAINTS SEEN BY MASSAGE THERAPISTS. SIMPLE MUSCLE TENSION IS OFTEN THE CAUSE. BUT MASSAGE MAY HELP WHEN THE CAUSE IS NOT SO SIMPLE. MASSAGE HAS BEEN USED TO RELIEVE PAIN AND PROMOTE HEALING BY INCREASING CIRCULATION TO WHIPLASH-INJURED NECK MUSCLES. MASSAGE OF THE SCALP IS USED FOR CHRONIC DISCOMFORT FROM HEADACHES, AND JAW MASSAGE IS USED TO EASE C JOINT. IN ADDITION TO MASSAGING THE AFFECTED AREA, A BACK AND NECK MASSAGE CAN SOMETIMES HELP RELIEVE POSTURE RELATED MUSCLE STRAIN.

A SMALL STUDY FROM NORWAY SUGGESTS THAT MASSAGE NOT ONLY RELAXES MUSCLES, BUT ALSO PUTS THE BODY'S OWN ANESTHETICS TO WORK ON PAIN. RESEARCHERS MEASURED THE BLOOD LEVELS OF BETA-ENDORPHINS (NATURALLY OCCURRING PAIN KILLERS) IN 12 VOLUNTEERS AFTER EACH UNDERWENT A 30 MINUTE MASSAGE. THE RESULT WAS A 16% AVERAGE INCREASE IN THE RELEASE OF ENDORPHINS IN THE BODY.

MASSAGE CAN ALSO HELP REDUCE OTHER SYMPTOMS OF INJURY SUCH AS EDEMA AND SWELLING. MASSAGE CAN STIMULATE THE CIRCULATION OF BOTH BLOOD AND LYMPHATIC FLUID, WHICH TEND TO POOL AROUND THE SITE OF AN INJURY. THE LYMPHATIC SYSTEM IS AN ADDITIONAL DRAINAGE ROUTE THAT REMOVES WASTES FROM THE TISSUES. THEORETICALLY, REDUCING SWELLING IN THIS MANNER ENCOURAGES HEALING BY ALLOWING OXYGEN AND NUTRIENT RICH BLOOD TO FLOW BACK TO THE TISSUES.

IN ADDITION TO THE BENEFITS MENTIONED ABOVE, MASSAGE CAN HELP REMOVE LACTIC ACID FROM FATIGUED MUSCLES. LACTIC ACID BUILD UP CAN OCCUR DURING EXERCISE, CAUSING MUSCLE CRAMPS. MASSAGE REALLY HELPS REDUCE PAIN AND FATIGUE. IN ADDITION TO ALL OF THESE VALUABLE BENEFITS, MASSAGE REPLACES STRESS AND TENSION WITH A PEACEFUL AND RELAXED STATE OF MIND.

**GIVE THE GIFT OF RELAXATION  
MASSAGE GIFT CERTIFICATES  
AVAILABLE**

**RED ROCK CHIROPRACTIC**  
**TREATMENT AUTHORIZATION**

Please Answer The Following Questions

Have you or are you currently suffering from any injuries, illnesses or other conditions that could possibly effect your treatment?

NO \_\_\_\_\_ YES \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medication?

NO \_\_\_\_\_ YES \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Are you pregnant?

NO \_\_\_\_\_ YES \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

I understand that the massage therapy given here at Red Rock Chiropractic is for the purpose of the relief from muscular tension, stress reduction or relaxation. I understand that the therapist does not treat or diagnose illness or disease. I further understand that it is recommended that I consult a physician before beginning the above treatments. Red Rock Chiropractic reserves the right to deny treatment due to medical reasons. I understand that Red Rock Chiropractic is not responsible for any lost or stolen items. I also understand that I am responsible for and assume the risk for any injury that I may sustain while on the premises and do hereby for myself my heirs, administrators assigns release, and forever discharge Red Rock Chiropractic its owners, operators, members agents, officers, and employees from any personal injury I may sustain while on the premises of Red Rock Chiropractic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**DR. MARGARET R. COLUCCI**

Red Rock Chiropractic & Wellness Center  
2085 Village Center Circle #110  
Las Vegas NV. 89134

(702)880-5335

**INFORMED CONSENT TO TREAT**

The information I have given this office and my treating doctor is complete and true to the best of my knowledge. I understand the risks associated this form of treatment and I will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary. They have not stated or implied any guaranteed of cure. "24 Hour notice of cancellation is required to avoid a broken appointment charge of \$40.00. I am responsible for payment of this charge.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMED CONSENT TO TREAT A MINOR CHILD**

The information I have given this office and my treating doctor pertaining to \_\_\_\_\_ is complete and true to the best of my knowledge. I understand the risks associated with this form of treatment and will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. They have not stated or implied any guaranteed of cure.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_