Therapeutic Massage

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs and exclude any techniques that may be medically unsuitable for you.

Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Phone (H) _____ (W) _____ E-Mail _____

Occupation _____ Referred by _____

Emergency Contact _____ Phone _____

Physician _____ Chiropractor _____

Sports/ Physical Activities _____

Current Medication/ OTC/ Supplements _____

_____

Please answer the following question to the best of your knowledge.

1. Have you had a professional massage before? ___ Yes ___ No
2. Do you have allergic reaction to oils, lotions or other substance put on your skin, or to any nuts? ___ Yes ___ No
3. Is there a particular area of your body in which you are experiencing tension, stiffness or other discomfort? __ Yes __ No

If yes, please describe _____

4. Do you have any particular goals for this appointment? _____

5. If you are currently under medical supervision, please explain? _____

6. Please list any accidents or operations _____
7. Please circle any conditions/ symptoms listed below that applies to you:

Allergies	Fibromyalgia or CFS	Pregnancy – if so, how far along?
Atherosclerosis	Fractures	Psoriasis
Athletes Foot/ Fungal Infection	Headaches	Rash/ Eczema
Artificial Joints	Heart Conditions	Recent Accident or Injury
Cancer or Tumors	High or Low Blood Pressure	Recent Surgery
Circulatory Disorder	HIV/ AIDS	Rheumatoid Arthritis/Osteoarthritis
Cold Sores/ Herpes	Joint Disorder	Scleroderma
Diabetes, Type I or Type II	Lung or Breathing Problems	Stroke or Blood Clots
Digestive Problems	Open Sores or Wounds	Swollen Glands
Easy Bruising	Osteoporosis	Ulcers
Epilepsy	Phlebitis	Varicose Veins

Contact Lenses Dentures Hearing Aid Difficulty lying on your Back, Front, Side

(Continued on other side)

8. Is there anything else about your health history that your massage therapist should know before planning you massage session?

_____

_____

_____(initials) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity and flexibility. I understand a massage therapist will never touch genitals, breast tissue or any other areas I instruct them not to touch. I understand massage therapists do not diagnose illness, disease or other physical or mental disorders, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have and keep the massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand that I have the right to refuse massage therapy treatment at any time during the session. Consent for Treatment: I authorize the performance of massage at City Lakes Chiropractic Clinic.

Signature _____ Date _____

ATTACHMENT A: COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

Note: According to the Minnesota Complementary and Alternative Health Care Freedom of Access Act CHAPTER No. 460-HOUSE File 3839- All unlicensed complementary and alternative health care practitioners shall provide to each complementary and alternative health care client prior to receiving treatment, a written copy of the complementary and alternative health care bill of rights. A copy must also be posted in a prominent location in the office of the unlicensed complementary and alternative health care practitioner. Reasonable accommodations shall be made for those clients who cannot read or who have communication impairments and those who do not read or speak English. The Complementary and Alternative Health Care client bill of rights shall include the following:

You will be receiving a treatment from Lynn Betzold CMT or Mary Staiger CMT for City Lakes Chiropractic Clinic, 2903 East 42nd Street, Minneapolis, MN 55406, (612)- 722-2147.

Lynn is a graduate of Phoenix Therapeutic Massage College, Phoenix, AZ. The 735 hour program included Anatomy, Physiology, Swedish Massage, Deep Tissue, and Trigger Point Therapy. She is a member of the American Massage Therapy Association (AMTA). Her professional experience as a massage therapist provider includes: Hospice Care, Health and Wellness Clinic, Health Club and Private Practice.

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARTY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed Complementary and Alternative Health Care Practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, athletic trainer or any other type of health care provider, the client may seek such services at any time."

ATTACHMENT B: COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

1. "THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARTY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed Complementary and Alternative Health Care Practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, athletic trainer or any other type of health care provider, the client may seek such services at any time."

2. Notice: A complementary and Alternative Health Care client has the right to file a complaint with the practitioner's supervisor, if any, and the procedure for filing complaints; you may notify the supervisor as stated in (2) or direct a written complaint to the supervisor listed.

3. Minnesota Department of Health Occupations Program, Metro Square Building, 121 East Seventh Place, Suite 400, St. Paul, MN 55101. Susan Winkelman, 651-282-5623. Notice: A client may file complaints with the office listed above.

4. Fees at City Lakes Chiropractic Clinic are as follows: Massage: 30 minutes = $39; 60 minutes = $69. Methods of payment: Cash, Check, Credit Card. All payments are due at the time of service.

5. Clients have a right to reasonable notice of changes in services or charges.

6. Massage Techniques such as gliding, holding, pressure, stretching, movement, breath coaching, imagery and energy work are used to facilitate the body's self-healing and enhance the sense of well being. These techniques may produce effect such as muscle relaxation, increased range of motion, increase circulation of blood and lymph, relief of muscle spasms, decreased pain, deeper breathing, greater awareness of the body and deep overall relaxation. Styles of Massage offered: Swedish, Deep Tissue and Trigger Point Therapy.

7. Clients have a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

8. Clients may expect courteous treatment and be free from verbal, physical or sexual abuse by the practitioner.

9. Client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client or otherwise provided by law.

10. Clients have a right to be allowed access to records and written information from records in accordance with section 144.335.

11. Other services available in the community include Center Point School and Clinic, 1313 South East 5th Street, Minneapolis, MN (612) 617-9090, Sister Rosalind School and Clinic, 2145 Ford Parkway, Suite 20, St. Paul, MN (651) 698-9123.

12. Clients have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance or other health programs.

13. Clients have the right to coordinated transfer when there will be a change in the provider services.

14. Clients may refuse services or treatment, unless otherwise provided by law.

15. Clients may assert the client's rights without retaliation.

Subd. 2. (ACKNOWLEDGEMENT BY CLIENT) Prior to the provision of any service, a complementary and alternative health care client must sign a written statement attesting that the client has received the Complementary and Alternative Health Care Client Bill of Rights.

I acknowledge receipt of this Client Bill of Rights and all attached documents and I have had the full opportunity to ask any questions I have about these rights. I understand my rights as a client.

Name (please print) _____

Signature _____ Date _____

City Lakes Chiropractic
2903 E. 42nd Street
Minneapolis, MN 55406
Ph. 612-722-2147

Massage Therapy Cancellation Policy Agreement

Massage Cancellation Policy
Please note we require 24-hour notice of change or cancellation of a massage appointment. This will allow enough time for our staff to attempt to schedule another client for that time.

Late Cancellations
If you call less than 24 hours (and up to 1 hour before scheduled appointment) to cancel your appointment you will be charged 50% of your scheduled massage session.

No Show
If we receive a phone call less than 1 hour before your scheduled appointment time, you arrive more than 5 minutes past your scheduled appointment time or you do not arrive for your appointment it will be considered a **no show**. In the case of a no show you will be responsible for full payment of your massage session.

*Cancellations are accepted by phone only at **612-722-2147**
We provide 24 hour voicemail for your convenience.

Agreement
I understand the above cancellation policy and by signing below I give my permission to the staff at City Lakes Chiropractic to call the numbers I have provided and leave a message if necessary with information regarding my massage appointment. I agree to notify City Lakes Chiropractic in writing of any change to my contact phone number(s). *Please note we do not make appointment reminder phone calls.

I understand and agree to the above Massage Therapy Agreement.

_____ _____
Printed Full Name Date

_____
Signature