Stretch: 1 @ $75.00/4 for $270.00 Massage: $65.00/50 minutes Cupping; $40.00

PLEASE WEAR WORKOUT CLOTHING, BASKETBALL SHORTS, SWEATPANTS FOR STRETCH SESSIONS. DO NOT WEAR JEANS OR BUSINESS ATTIRE AS THESE PROHIBIT MOBILITY

SEMINOLE CHIROPRACTIC MEDICINE

Therapeutic Modalities

Confidential Patient Health Record

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: _____/_____/_____ Age: _____ Sex: Male/Female

Address: _____ Apt #: _____

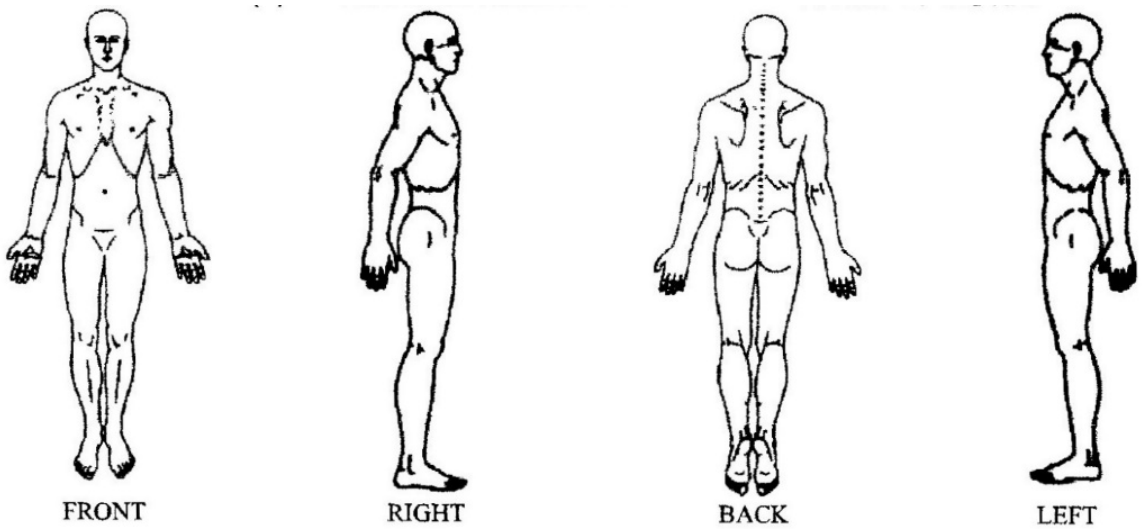
City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Emergency Phone: _____

The following information will be used to help plan safe and effective therapeutic modality sessions. Please answer the questions to the best of your knowledge.

1. Reason for your visit _____
2. Are you pregnant? ❑ Yes ❑ No If yes, what trimester? _____
3. Have you had therapeutic massage before? ❑ Yes ❑ No If yes, how often: _____
4. Do you have difficulty lying on your front, back or side? ❑ Yes ❑ No If yes, explain: _____
5. Do you have any allergies to oil, lotions, or ointments? ❑ Yes ❑ No If yes, Which ones? _____
6. Do you have sensitive skin? ❑ Yes ❑ No
7. Are you wearing ❑ contact lenses, ❑ dentures, ❑ hearing aid?
8. Do you have any scars, lumps, bruises, bumps, cuts that we should be aware of? ❑ Yes ❑ No
9. Do you have any goals in mind for this session? ❑ Yes ❑ No If yes, explain: _____
10. Do you currently have a fever, cold or flu like symptoms? ❑ Yes ❑ No If yes, explain: _____
11. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
    ❑ Yes ❑ No If yes, explain and circle below: _____



Medical History

In order to plan a therapeutic modality session that is safe and effective, we need some general information about your medical history.

12. Are you currently under medical supervision? ❑ Yes ❑ No If yes, explain: _____
13. Do you see a chiropractor? ❑ Yes ❑ No If yes, how often? _____
14. Are you currently taking any medications? ❑ Yes ❑ No If yes, please list: _____

    _____
15. Please check any conditions listed below that applies to you:

- ❑ Contagious skin condition
- ❑ Open sores or wounds
- ❑ Easy bruising
- ❑ Recent accident or injury
- ❑ Recent fracture
- ❑ Recent surgery
- ❑ Artificial joint
- ❑ Sprains/ strains
- ❑ Current fever
- ❑ Swollen glands
- ❑ Allergies/ sensitivity
- ❑ Heart condition
- ❑ High or low blood pressure
- ❑ Circulatory disorder
- ❑ Varicose veins
- ❑ Atherosclerosis
- ❑ Phlebitis
- ❑ Deep vein thrombosis/ blood clots
- ❑ Joint disorder/ Rheumatoid arthritis/ tendonitis
- ❑ Osteoporosis
- ❑ Epilepsy
- ❑ Headaches/ migraines
- ❑ Cancer
- ❑ Diabetes
- ❑ Decrease sensation
- ❑ Back/ neck problems
- ❑ Fibromyalgia
- ❑ TMJ
- ❑ Carpal tunnel syndrome
- ❑ Tennis elbow
- ❑ Pregnancy (months: _____)

Please explain any conditions that you have marked above: _____

_____

16. Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage/modality session for you? _____

    _____

For massage only: Draping will be used during the massage session. Only the area being worked on will be uncovered. Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Parent or legal guardian for any client under the age of 18 must provide informed written consent.

I _____ (printed name) understand that the therapeutic modality I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or techniques may be adjusted to my level of comfort. I further understand that therapeutic modality should not be constructed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said during the session given should be constructed as such. Because therapeutic modality should not be performed 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. _____ initials.

YOU UNDERSTAND AND VOLUNTARILY ACCEPT ANY RISKS ASSOCIATED WITH YOUR SERVICES OR ANY USE OF FACILITIES WILL NOT BE LIABLE FOR ANY INJURY OR DAMAGE INCLUDING WITHOUT LIMITATION, PERSONAL, BODILY, OR MENTAL INJURY, ECONOMIC LOSS, OR ANY OTHER DAMAGE TO YOU, YOUR SPOUSE, GUEST, UNBORN CHILD, OR OTHERS RESULTING FROM THE NEGLIGENCE OF OR ACTING ON BEHALF OR ANYONE USING FACILITIES.

By signing below, you agree that you have read and agree to all terms and conditions of this Liability Release.

Signature: _____ Date: _____