Dr. Timothy Bortz, DC
3260 Murrell Rd. Suite 101
Rockledge, FL. 32955
(321) 631-1100
www.BrevardChiro.com

MASSAGE AND BODYWORK CONSENT FORM

PERSONAL INFORMATION

First Name:_____ M.I._____ Last Name:_____ Preferred Name: _____

Address:_____ City:_____ State: _____Zip:_____

Birthdate:_____/_____/_____ Age_____ Gender: ☐ Male ☐ Female ☐ Unspecified SSN:_____/_____/_____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Home Email: _____ Work Email:_____

By providing my email address, I authorize my Doctor and/or Massage Therapist to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) ☐ Home ☐Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Home Email ☐ Work Email

Occupation: _____ Employer: _____

Drivers License #: _____

Spouse/Parents Name: _____ Spouse/Parents Occupation: _____

Spouse/Parents Employer: _____ Spouse/Parents Social Security #: _____

Spouse/Parents Work #: _____ Spouse/Parents Cell #: _____

Emergency Contact

Name: _____ Relation to You: _____

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

How Did You Hear About Us?

Please be as specific as possible so we can track how our patients FIRST heard about us!

☐BrevardChiro.com ☐BrevardDisc.com ☐Google ☐Drive-by ☐Email Blast ☐TV Commercial ☐Radio
☐Facebook ☐Yelp ☐Direct Mailer ☐YouTube ☐School ☐Work ☐Clinic Employee: _____
☐Magazine Ad:_____ ☐Newspaper:_____ ☐Referred by Friend:_____
☐Current Patient of Physician/NP ☐Other: _____

Your Health Attitude

Please mark which one applies to you

____ **Pain Relief** - I only consult with a doctor when I am in pain. I discontinue treatment as soon as it has cleared up.
____ **Prevention** - In addition to symptomatic treatments, I consult with doctors to keep problems from appearing or re-occurring.
____ **Maximizing Health and Wellness** - I actively pursue health so I can feel better and perform better. So I can be the best I can be.

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Client Name: _____ ***Age:*** _____ ***Todays Date:*** _____

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated.

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No How recently? _____

What are your massage or bodywork goals? _____

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

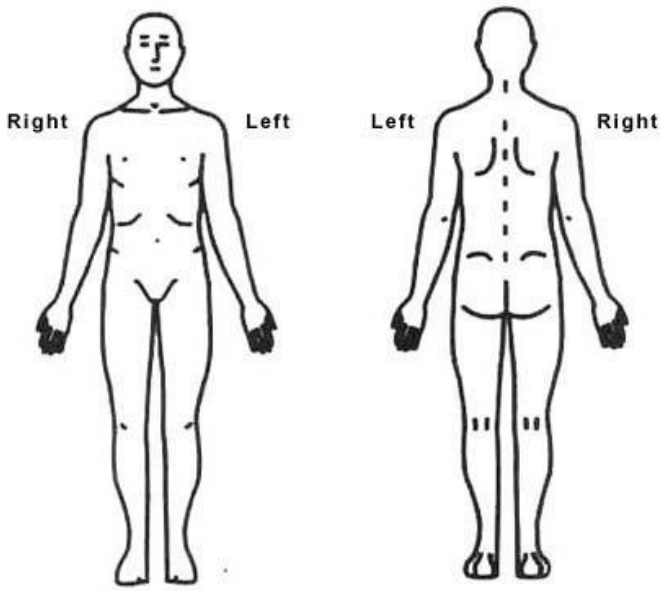
___ Yes ___ No Do you frequently suffer from stress?
___ Yes ___ No Do you have diabetes?
___ Yes ___ No Do you experience frequent headaches?
___ Yes ___ No Are you pregnant? 1st 2nd or 3rd trimester?
___ Yes ___ No Do you suffer from arthritis?
___ Yes ___ No Are you wearing contact lenses?
___ Yes ___ No Are you wearing dentures?
___ Yes ___ No Do you have high blood pressure?
___ Yes ___ No Taking high blood pressure medication?
___ Yes ___ No Do you suffer from epilepsy or seizures?
___ Yes ___ No Do you suffer from joint swelling?
___ Yes ___ No Do you have varicose veins?
___ Yes ___ No Do you have any contagious diseases?
___ Yes ___ No Do you have osteoporosis?
___ Yes ___ No Skin, scent, food, herb or nut allergies?

___ Yes ___ No Do you bruise easily?
___ Yes ___ No Any broken bones in the past two years?
___ Yes ___ No Accidents, injuries or surgeries in the last year?
___ Yes ___ No Tension/soreness in a certain area?
Please specify: _____
___ Yes ___ No Do you have cardiac or circulatory problems?
___ Yes ___ No Do you suffer from back pain?
___ Yes ___ No Do you have numbness or stabbing pains?
___ Yes ___ No Sensitive to touch/pressure in any area?
Please Specify: _____
___ Yes ___ No Have you ever had surgery? Explain below.
___ Yes ___ No Other medical condition, or are you taking any medications I should know about?

Comments: _____
_____

Please make note of any specific areas you would like the massage therapist to concentrate on (or avoid) during the session.

O = FOCUS HERE
X = DO NOT TOUCH



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Massage Policy Statement

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all patients, the following policies are honored:

Cancellations

Three (3) hour advanced notice is required when needing to reschedule or cancel an appointment. This allows the opportunity for someone else to schedule an appointment. At Brevard Chiropractic & Injury Center's discretion, clients that fail to cancel within 3 hours may be subject to a fee. This amount due must be paid prior to your next scheduled appointment. Gift certificates will be voided in lieu of the fee.

No-Shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their missed appointment.

Late Arrivals

Please arrive for your appointment 10-15 minutes prior to the scheduled starting time. This allows you the time to fill out the appropriate client forms, change and prepare for the service. If you arrive late, your session may be shortened in order to accommodate the appointments of those who follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Out of respect and consideration, to your therapist and other clients, please plan accordingly and be on time.

Professional Boundaries

Requests for sexual activity is not acceptable in any circumstance, and will result in a termination of the session, with no refund of the treatment fee. Proper draping to protect client's modesty will be maintained at all times. Hip & gluteal area will be massaged only with permission and can be worked through the draping if requested.

I understand that the massage/bodywork 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 strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork 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. I also understand 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 scheduled appointment. #MM22116

Patient Signature _____ Date _____

Therapist Initials _____

Consent to Treatment of Minor: By my signature below, I hereby authorize therapists employed with Brevard Chiropractic & Injury Center to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____