INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I understand that the following may be common side effects or risks from massage therapy, bruising, soreness and soft tissue damage.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand that should I need to cancel an appointment I need to give a 24-hour notice. If I cancel or no show within less than 24 hours, I may be charged the full price of the missed appointment.
_____Initial

Patient Name _____ Signature of Patient/Guardian _____

CUPPING CONSENT

- ☐ I hereby consent for Larson Family Chiropractic, to use the therapeutic method of cupping.
- ☐ I understand that the cupping therapy has been explained to me, and I understand that cupping will leave bruise-like marks that will last several days depending on the severity of my condition. While most marks disappear or fade after a few days there are times when it can take up to 15 days in rare cases, and 21 days to fully clear.
- ☐ It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.These areas of bruising or discoloration are typically not painful, but on occasion can have soreness, itching, and soreness surrounding the muscles.
- ☐ I understand that all treatments at Larson Family Chiropractic are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.

- ☐ I understand that cupping treatments can be a "detoxifying" treatment process and as a result, I may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to relieve these symptoms quickly. In some cases headaches and minor body aches may be experienced.
- ☐ I understand that I should avoid caffeine, alcohol, sugary foods, and drinks, dairy and processed meats and I should consume an abundance of clean water.
- ☐ I understand that the first time I experience cupping my body's immune system can temporarily react to this release as it might with the flu, producing flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release
- ☐ I understand that cupping therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I am hungry or thirsty.
- ☐ I understand that I should avoid exposure to cold, wet, and or dry windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4-6 hours. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.

Contradictions

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patient or those who have been ill
- Abdomen and lower back on pregnant women
- Diabetics, especially those with uncontrolled blood sugar as they may not be able to feel pain properly
- Those who are unable to experience heat or pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy

I _____ agree to allow the cupping practitioner to perform cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Date_____ Signature of Client _____

Print Name _____

Date _____ Signature of Practitioner _____

Print Name _____

HEALTH HISTORY FORM – MINIMUM REQUIREMENTS

Name: _____ **Date:** _____

Address: _____ **Phone number:** _____

Date of birth: _____ **Referred by:** _____

Sports & activities: _____

Current medications: _____

Are you under medical care for any of the following: (circle)

heart conditions	high/low blood pressure	fainting or dizziness
varicose veins	phlebitis/circulatory problems	headaches or migraine
neck injury	back injury	jaw or ear pain
osteoporosis	rheumatoid arthritis	osteoarthritis
cancer	kidney disease	skin conditions
diabetes	asthma/respiratory	fibromyalgia
Crohn's disease	pelvic inflammatory disease	epilepsy
nervous disorders	whiplash	other:

Have you received care from any of the following: (circle)

physiotherapist chiropractor massage therapist naturopath

other: _____

Reason for treatment: _____

Have you had surgery in the past? Y N If yes, for what? _____

Have you had any fractures/sprains in the past? Y N If yes, where? _____

Have you had any serious illnesses in the past? Y N If yes, what? _____

Did the current injury result from a motor vehicle accident or workplace injury? Y N

Have you had any of the following regarding your current condition: (circle)

physician's examination x-ray other diagnostic tests

What relieves your pain? _____

What aggravates your pain? _____

Signature of Patient (or Guardian): _____