Massage Cancellation Policy

Fort Wayne Chiropractic

In order to give patient's an adequate amount of time to schedule a massage, I ask that you please cancel appointments within 24 hours. Please call Dr. Hough's office at 492-8300 to cancel appointments.

If 24 hour notice is not given, that appointment will be counted as a failed appointment.

Please make every effort to be at your appointment on time. If you are running late, please call the office and notify us of your estimated arrival. Appointments are scheduled in 30 minute increments. If you show up late to your appointment, your 1-hour massage may be shortened to a 30 minute massage in order to give the next patient their full appointment time. Appointments will not be lengthened to accommodate your lateness.

It will also be counted as a failed appointment if you do not show up to your appointment.

There will be a $35 fee on the second failed appointment.

Please know that this policy was put in place in order to be fair to patients and in respect for both patient's and my time. Thank you all and I look forward to seeing you!

_______________________________________ ____________________

Patient Signature Date

Massage Therapy Consent Form

Fort Wayne Chiropractic

____

Patient's Name (please print)

By my signature below, I acknowledge that I have agreed to receive one or more massage sessions from Fort Wayne Chiropractic. I understand that:

1. Neither Fort Wayne Chiropractic nor the massage therapist has made any guarantees or promises regarding the results of this process upon me. I understand that massage therapy is for the purpose of relief of muscle tension or spasms, increasing circulation, restoring muscle and joint function, reducing edema, reducing inflammation or reducing pain.

2. Massage is not involved with the treatment of disease, illness or disorders of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. Likewise, the therapist shall not diagnose or treat any illness, disease, or other physical or mental disorder of the person; and nothing said or done to me by the therapist should be construed as such.

3. I am responsible for obtaining medical clearance from my health care provider(s) if I have a currently diagnosed medical condition that could be a contraindication for massage. I shall provide written documentation to Fort Wayne Chiropractic from my provider if I have a contraindicating medical condition.

4. Fort Wayne Chiropractic and the therapist have the right to decline to provide care or to terminate a session at anytime, and for any reason.

5. It is necessary for the therapist to touch and observe my body in order to conduct this process. I am aware that massage work is performed directly on the skin with the use of lubricants, and that all areas of my body not being massaged will remain draped. I give Fort Wayne Chiropractic and the therapist full permission to work on my body in such a way. I acknowledge that I also have the right to decline treatment to any part of my body, and to request modifications to the session plan

6. In my role as a Client, it is my responsibility to:
    a. Arrive for clinic massage sessions on time; b. Provide accurate information on my health history on the forms given to me by Fort Wayne Chiropractic, and keep Fort Wayne Chiropractic updated as to changes in my health status upon return visits; c. Provide the therapist with feedback on their massage work both during and after sessions, as requested.

7. Patient records are the property of Fort Wayne Chiropractic, and their confidentiality shall be maintained at all times by Fort Wayne Chiropractic. I understand that my health history and treatment-related information may be discussed between the massage therapist and Dr. Hough for educational purposes and for treatment purposes only.

____ _________________________

Patient Signature Date

Pain Assessment – Initial

Patient Name ________________________________ **Date of Birth:** ____________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box.**

Were you referred to us by another medical provider for your complaints? If yes, who? ____________________________________

Complaint #1 (main complaint)

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ____________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ______________________________

What decreases your symptoms? (ex: lying down) ____________________ **What makes them worse?** ____________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ____________________

What medical care have you received for this latest occurrence of symptoms? ______________________________

Complaint #2

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ____________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ______________________________

What decreases your symptoms? (ex: lying down) ____________________ **What makes them worse?** ____________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ____________________

What medical care have you received for this latest occurrence of symptoms? ______________________________

Patient Signature: ______________________________ **Date:** ____________________

Turn over for side 2 →

Pain Assessment – Initial (page 2)

Patient Name ____ **Date of Birth:** __________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box. The doctor will only work on areas that you mark on this pain assessment.**

Complaint #3

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ________________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ________________________ **What makes them worse?** ________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________

What medical care have you received for this latest occurrence of symptoms? ____

Complaint #4

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ________________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ________________________ **What makes them worse?** ________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________

What medical care have you received for this latest occurrence of symptoms? ____

Patient Signature: ____ **Date:** ____________________

Health History

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name ________________________________ **Date**: ________________

Is this massage medically necessary (is it for a medical condition, injury, surgery)? ☐ Yes ☐ No

Do you have a physician referral/prescription? ☐ Yes ☐No

Have you ever received professional massage before? ☐ Yes ☐ No **How recently?** __________________________

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

What are your goals/expected outcomes for receiving massage? ____

____

Are you pregnant? ☐ Yes ☐ No

Have you had any injuries or surgeries in the past that may influence today's treatment?

____

____

Current Medications (include dosage and frequency): ❒ **NONE**

____________________________ ______________________________ ___________________________

____________________________ ______________________________ ___________________________

Please indicate any of the following health conditions that you currently have. Please answer honestly, as massage may not be indicated for the following conditions

Blood Clots Infections Congestive Heart Failure Contagious Disease Pitted Edema

Please indicate conditions that you have currently or have had in the past.

Past	Current	Past	Current	Past	Current
❒	❒ Broken bones	❒	❒ Scoliosis	❒	❒ Gas, bloating, constipation
❒	❒ Numbness or tingling	❒	❒ Varicose veins	❒	❒ Kidney disease, infection
❒	❒ Swelling	❒	❒ Cancer	❒	❒ Osteoporosis, degenerative spine/disc
❒	❒ Bruise easily	❒	❒ Neurological	❒	❒ Muscle or joint pain/stiffness, arthritis
❒	❒ Sensitive to touch/pressure	❒	❒ Epilepsy, seizures	❒	❒ Endocrine/thyroid conditions
❒	❒ High/Low blood pressure	❒	❒ Headaches, Migraines	❒	❒ Depression, anxiety
❒	❒ Stroke, heart attack	❒	❒ Digestive conditions	❒	❒ Memory loss, confusion, easily overwhelmed
❒	❒ Shortness of breath, asthma	❒	❒ Allergies		
❒	❒ Dizziness, ringing in ears	❒	❒ Diabetes		

If I experience any pain or discomfort during my sessions 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 should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage providers are not qualified to perform spinal or skeletal adjustment, 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 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 changed 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 and illicit or sexually suggestive remarks or advances made by me will result in mediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Patient Signature ____ **Date** ________________