KENNETH B. FREDERICK, D.C.
KAREN BUSSO, D.C.

FREDERICK CHIROPRACTIC
2501 Mile Hill Dr. A-101
Port Orchard, WA 98366
Phone: 360-895-4843/ Fax: 360-895-4210

Massage Therapy

Date: _____

Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Work Phone: _____
Age: _____ Birth Date: _____ Marital Status: S M W D | EMAIL: _____
Occupation: _____ Employer: _____ Location (City): _____
Name of Spouse: _____ Birth Date of Spouse: _____
Spouses SS # (for insurance) _____ Spouses Occupation: _____
Emergency Contact (*If different from Spouse*): _____
Phone: _____ Address: _____ Relationship: _____

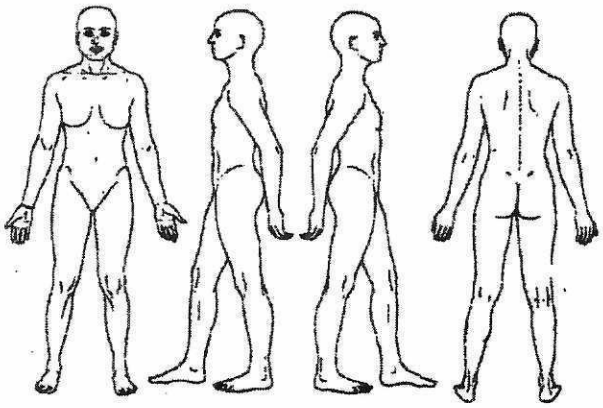
How were you referred to our office? _____

Insurance Company: _____ ID#: _____ Group#: _____

Medical History:
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you ever had a professional massage before? Yes / No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front / back / side? (Circle any that apply.)
   If yes, please explain: _____
3. Do you have any allergies to oils, lotions, or ointments? Yes / No
   If yes, please explain: _____
4. Do you have sensitive skin? Yes / No
5. Are you wearing contact lenses / dentures / a hearing aid(s)? None (Circle any that apply.)
6. Do you sit for long hours at a workstation / computer / driving? None (Circle any that apply.)
7. Do you perform any repetitive movements in your work, sports or hobbies? Yes / No
   If yes, please describe: _____
8. When you experience stress in your work, family or other aspects of your life, how does it affect your health?
   Muscle tension / Anxiety / Insomnia / Irritability / Other: _____
   _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or discomfort?
   Yes / No If yes, please identify: _____
10. Do you have any particular goals in mind for this massage session? Yes / No
    If yes, please explain: _____

Massage - Medical History Pg. 2



Circle any specific areas you would like the massage therapist to concentrate on during the session.

11. Are you currently under medical supervision? Yes / No
    If yes, please explain: _____

12. Do you see a chiropractor? Yes / No If yes, how often? _____
    If yes, who do you see? _____

13. Are you currently taking any medication? Yes / No
    If yes, please list: _____

14. Please check any condition below that applies to you:

	Allergies / Sensitivity		Artificial Joint		Atherosclerosis
	Back / Neck Problems		Cancer		Carpal Tunnel Syndrome
	Circulatory Disorder		Contagious Skin Condition		Current Fever
	Decreased Sensation		Deep Vein Thrombosis / Blood Clots		Diabetes
	Easy Bruising		Epilepsy		Fibromyalgia
	Headaches / Migraines		Heart Condition		High or Low Blood Pressure
	Joint Disorder / Rheumatoid Arthritis / Osteoarthritis / Tendonitis		Open Sores Or Wounds		Osteoporosis
	Phlebitis		Recent Accident Or Injury		Recent Fracture
	Recent Surgery		Sprains / Strains		Swollen Glands
	Tennis Elbow		TMJ		Varicose Veins
	Pregnancy How many months? _____				

Explain any condition marked above: _____

15. Is here anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Massage - Medical History Pg. 3

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

I, _____ (print name) understand that the massage 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 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 that I am aware of. I understand that massage 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 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 therapists' part should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Parent (if client is under 18): _____

MASSAGE POLICY

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

Multiple appointments can be scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. This office reserves the right to $50.00 charge for missed appointments and those cancelled without 24-hour notice.

Patient's Name (Print): _____ Date: _____

Patient or Parent's Signature: _____