Health Information (Page 1 of 3)

Health and Medical History Information Welcome! Some massage techniques should not be performed under certain medical conditions, so please be complete and honest with your answers. I thank you for taking your time with this form and answering all the medical history questions honestly.

Client Contact Information Name: ____

Date: ____________ Date of Birth: ________________ Gender________

Address:____

Phone:______________________________E-mail:___________________________________

Referred By: _____________________________

Emergency Contact________________________ Phone: ______________________

Relationship to you: _____________

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

Are you wanting to have insurance pay for your treatments? □Yes □No *If Yes:

Please fill out the Insurance Billing/Release Form. Massage Information

Have you ever received professional massage/bodywork before? □Yes □No

How long ago? _____________

What modality of massage/bodywork do you prefer (Deep Tissue, Trigger Point etc.)?

____

What kind of pressure do you like? Light Medium Firm What are your goals/expected outcomes from receiving massage?

____

____

Please list your current symptoms/issues (stress, stiffness, pain, numbness/tingling, swelling etc.:)____

____

____

Do these symptoms interfere with your daily activities (sleep, exercise, work, childcare)

□Yes □No

Please list any medications you are currently taking:

____

____

____

If you are taking pain killers or muscle relaxers, please list when you last took your medication

____

Are you pregnant? □Yes □No Are you wearing contacts? □Yes □

Health Information (Page 2 of 3)

Name: ______________________________

Have you had an injury (car accidents, sports incident etc.) or any surgeries in the past 5 years? ▫Yes ▫No If yes please list:

____

____

Please circle any of the following health conditions that you currently have or have had in the past. If you are unsure, feel free to ask. (Blood clots, infections, congestive heart failure, contagious diseases, pitted edema, high blood pressure or any of the * conditions may be contraindicated to massage, so please be as accurate as you can be. Please also indicate any treatment received for the conditions.)

Past Current Muscle or Joint pain or stiffness ______________________________

Past Current Numbness or Tingling ______________________________

Past Current Swelling ______________________________

Past Current Bruise Easily ______________________________

Past Current Sensitive to touch/pressure ______________________________

Past Current *High/Low blood pressure (is it controlled by medication?) ______________________________

Past Current *Stroke, Heart Attack ______________________________

Past Current *Varicose veins ______________________________

Past Current Shortness of breath, asthma ______________________________

Past Current *Cancer ______________________________

Past Current Neurological (MS, Parkinson's, Chronic Pain) ______________________________

Past Current *Epilepsy, Seizures ______________________________

Past Current Headaches, Migraines ______________________________

Past Current Dizziness, Ringing in ears ______________________________

Past Current Digestive conditions ______________________________

Past Current Gas, bloating, constipation ______________________________

Past Current *Kidney disease, infection ______________________________

Past Current Arthritis (rheumatoid, osteoarthritis) ______________________________

Past Current Osteoporosis, Degenerative spine/disk ______________________________

Past Current Scoliosis ______________________________

Past Current *Broken bones ______________________________

Past Current Allergies (please include allergies to lotions or scents) ______________________________

Past Current Diabetes ______________________________

Past Current *Endocrine/Thyroid conditions ______________________________

Past Current Depression, anxiety ______________________________

Past Current Memory Loss, confusion, easily overwhelmed ______________________________

Is there anything else you think I should know?

____

____

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Health Information (page 3 of 3)

Please Indicate on the body map where you have pain or where your symptoms are:

Consent for Treatment

I hereby consent for my therapist to treat me with massage therapy after assessment, examination and explanation of techniques recommended. I acknowledge the therapist is not a physician and doesn't diagnose illness or disease or any other physical or mental disorder. I clearly understand massage is not a substitute for a medical examination. I understand that there are other option I may seek if massage doesn't solve my needs such as chiropractic or physical therapy. I understand no assurances or guarantees have been made to me as to the results of this treatment. I understand that as with any treatment there may be risks. Risks of massage include but are not limited to: prolong position discomfort, temporary pressure pain, skin sensitivity to topicals. I assume responsibility for those risks. I understand that the massage therapist must be fully aware of any existing medical conditions. I have completed my health intake form accurately to the best of my knowledge. I also agree to keep the therapist up to date of any new conditions or medications. I will tell the therapist if the pressure is too great so they can adjust pressure to my comfort. 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. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic. I have been given a chance to ask any questions about this or any other consent form and about the massage treatment to my satisfaction.

Client Signature: ____

Date: ____________

Printed Name: ____

Parent or Guardian Signature (in case of minor):

____

Massage Provider Name: ___________________________

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Informed Consent for Massage Therapy Modalities and Treatments

* Please Initial on each line**

_____ I hereby request and consent to the performance of massage therapy treatments and other modality within the therapist's scope of practice on me (or the patient named below for whom I am legally responsible) by the massage provider listed below.

_____ I have been informed that although rare, side effects may result from a massage therapy treatment. These could include but are not limited to some minor and temporary muscle pain or tenderness from deep pressure that may last a few days, skin irritation from lotions/oils, pain from prolonged position, headache, bruising, swelling, numbness, nausea, and the temporary aggravation of pre-existing conditions.

_____ I have had an opportunity to discuss with the massage therapist named below the nature, benefits and procedures of massage and understand that results are not guaranteed. I have been informed that I may stop treatment at any time during the session.

____ I understand that the massage therapy procedures and techniques used by the massage provider listed below are for therapeutic relief and stress management. At no time will I solicit any sexual suggestions or requests. I further understand that the massage provider will not tolerate any such solicitation. If this occurs, the massage provider will end the treatment session and I will be responsible for payment of the full treatment.

_____ I do not expect the massage provider to be able to anticipate all risks and complications. I wish to rely on the therapist to exercise judgment during treatment that the therapist feels are best, based upon the facts then known. Further, I affirm that I may be advised by the massage provider named below to consult a physician or another health care professional regarding conditions that are out of the therapist's scope of practice, or if massage therapy does not help the condition.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I have had the opportunity to request a copy of this consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Understanding all of this, I give my consent to receive care.

Printed Name: ________________________________

Signature: ____

Date: __________

Massage Provider Name: ____________________

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