Nick Conrad Massage Therapy
Kirkland, WA 562.217.5510 nickmassage.com

Health Information

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Massage Information

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

How recently? _____

What types of massage/bodywork do you prefer? _____

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

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

_____

_____

How do you feel today? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

List the medications you currently take:

_____

_____

Are you pregnant?	Yes ☐ No ☐	Are you wearing a wig/hairpiece?	Yes ☐ No ☐
(Optional) Have you been anxious?	Yes ☐ No ☐	Are you wearing dentures?	Yes ☐ No ☐
(Optional) Have you been depressed?	Yes ☐ No ☐	Are you wearing hearing aids?	Yes ☐ No ☐

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Health History

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

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current ☐ Past ☐ Muscle or joint pain _____
Current ☐ Past ☐ Muscle or joint stiffness _____
Current ☐ Past ☐ Numbness or tingling _____
Current ☐ Past ☐ Swelling _____
Current ☐ Past ☐ Bruise easily _____
Current ☐ Past ☐ Sensitive to touch/pressure _____
Current ☐ Past ☐ High/Low blood pressure _____
Current ☐ Past ☐ Stroke, heart attack _____
Current ☐ Past ☐ Varicose veins _____
Current ☐ Past ☐ Shortness of breath, asthma _____
Current ☐ Past ☐ Cancer _____
Current ☐ Past ☐ Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current ☐ Past ☐ Epilepsy, seizures _____
Current ☐ Past ☐ Headaches, Migraines _____
Current ☐ Past ☐ Dizziness, ringing in the ears _____
Current ☐ Past ☐ Digestive conditions (e.g. Crohn's, IBS) _____
Current ☐ Past ☐ Gas, bloating, constipation _____
Current ☐ Past ☐ Kidney disease, infection _____
Current ☐ Past ☐ Arthritis (rheumatoid, osteoarthritis) _____
Current ☐ Past ☐ Osteoporosis, degenerative spine/disk _____
Current ☐ Past ☐ Scoliosis _____
Current ☐ Past ☐ Broken bones _____
Current ☐ Past ☐ Allergies _____
Current ☐ Past ☐ Diabetes _____
Current ☐ Past ☐ Endocrine/thyroid conditions _____
Current ☐ Past ☐ Depression, anxiety _____
Current ☐ Past ☐ Memory Loss, confusion, easily overwhelmed _____

Comments:

_____

_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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/bodywork practitioners 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner'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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

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COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐
4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

   Location: _____
5. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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