

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:
\_\_\_\_\_
\_\_\_\_\_

Have you been anxious? Yes [ ] No [ ] Are you wearing contacts? Yes [ ] No [ ]
Have you been depressed? Yes [ ] No [ ] Are you wearing dentures? Yes [ ] No [ ]
Are you pregnant? Yes [ ] No [ ] Are you wearing hearing aids? Yes [ ] No [ ]

### 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:

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### 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: \_\_\_\_\_



# 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

***The following questions are specific to a new aspect of COVID-19 involving blood coagulation.***

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes  No
7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes  No
8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? 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 have been offered a copy of this consent form. \_\_\_\_\_

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 (in case of a minor): \_\_\_\_\_ Date: \_\_\_\_\_

