Confidential Client Intake and Medical History Form

Name:_____ DOB:_____ Date:_____

Occupation:_____ Referred by:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Primary Physician:_____ Date of Last Physical:_____

Massage Experience

Have you had a professional massage? ◯ Yes ◯ No

Health History

(circle if applicable and date if current)

Musculoskeletal
Bone/joint disease
Bursitis/tendonitis
Arthritis/gout
Jaw (TMJ)
Lupus
Spinal problems
Osteoporosis
Migraine/headache

Circulatory
Heart condition
Phlebitis/varicose vein
Blood clot
Blood pressure
Lymphedema
Thrombosis/embolism

Respiratory
Breathing difficulty
Allergies, specify:
_____
Emphysema
Sinus Problems

Nervous System
Shingles
Numbness/tingling
Pinched Nerve
Chronic Pain
Paralysis
Multiple Sclerosis
Parkinson's Disease

Reproductive
Pregnant, stage:_____
Ovarian problems
Prostate problems

Skin
Allergies, specify:
_____
Rashes
Cosmetic surgery
Athlete's foot
Herpes/cold sore

Digestive
IBS
Bladder problems
Kidney problems
Colitis
Chrohn's Disease
Ulcers

Psychological
Anxiety/stress
Depression

Other
Cancer/tumor
Diabetes
Drug/Alcohol use
Tobacco use
Contact lenses
Hearing aids

Any other medical condition:_____

Please explain:_____

List medications you are currently taking:_____

(continued on back)

Current Health Form

What is your reason for your initial visit?_____

Are you experiencing discomfort, stiffness, pain? If yes, where?_____

What are your exercise habits?_____

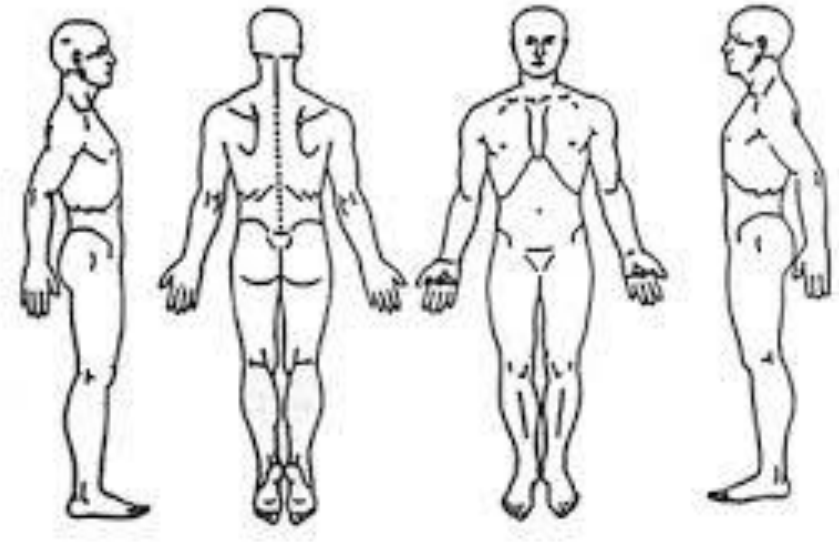
Have you recently had surgery, injury, or areas of inflammation?_____

List allergies to oils, lotions, creams, etc:_____

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 therapist's part should I fail to do so.

Signature:_____ Date:_____

Please circle any areas of discomfort or areas you would like the therapist to focus on



Thank you!

COVID-19 HEALTH INFORMATION & INFORMED CONSENT

In light of the COVID-19 public health crisis. Please read and fill out this form carefully in order to make a fully informed decision about receiving services during this time.

COVID-19 Information

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-like symptoms (such as 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 and respiratory rate up without problem? ◯ Yes ◯ No

7. Have you had a new muscle aches or pain since the emergence of the virus? ◯ Yes ◯ No

8. Have you seen any new marks, rashes, bumps, or other lesions on your skin? ◯ Yes ◯ No

Consent for Treatment

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

I understand that the novel corona virus (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 blood coagulation and clots may be a side-effect of COVID-19 infection. Massage would not be indicated if I have a blood clot and could result in serious injury or death. I understand this risk, and to the best of my ability, determine that I do not have any symptoms of a blood clot which could include swelling, pain, tenderness, discoloration, bumps, spots, rashes, lesions or no symptoms. _____

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: _____