HCM | WELLNESS CENTER

Massage Therapy Consultation

Name _____ Date _____

Address _____ Cell Phone _____

City State Zip _____ Home Phone _____

Email _____ Date of Birth _____

Emergency contact name / number _____

Physician name / number _____

Are you under the age of 17? If yes, you must have the written consent of your parent or guardian to receive massage therapy services.

Please check below all that apply:

- ☐ Spinal Problems
- ☐ Phlebitis /Varicose Veins
- ☐ Allergies
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Bruise Easily
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ Heart attack
- ☐ Heart disease
- ☐ Stroke
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ Chronic congestive heart failure
- ☐ Injuries
- ☐ Smoke
- ☐ Diabetes
- ☐ Vertigo/dizziness
- ☐ Active Cancer
- ☐ Joint Replacement
- ☐ Shoulder ☐L ☐R
- ☐ Hip ☐*L* ☐*R*
- ☐ Knee ☐*L* ☐*R*
- ☐ Fibromyalgia
- ☐ Hearing loss
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Sensory loss/change
- ☐ Sciatica
- ☐ Seizures
- ☐ Numbness/tingling
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Tendinitis
- ☐ Jaw pain TMJ
- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme disease
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Infectious skin cond
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric disorder
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Currently under a doctor's care? ☐ Y ☐ N Currently Pregnant? ☐ Y ☐N Due Date _____

Please explain any checked above: _____

_____

Any medical conditions your therapist should be aware of: _____

_____

Current Medications: _____

_____

Areas of Pain/Tension: _____

Areas to be avoided: _____

Massage therapy is not a substitute for medical examination or diagnosis. It is recommended that you see a physician for any physical ailments that you may have. You understand that the massage therapist does not prescribe medical treatments or pharmaceuticals, and does not perform any spinal adjustments. You are aware that if you have any serious medical diagnosis you must provide a physician's written consent prior to services. **Initials** _____

The massage therapist will not perform breast massage on female clients. **Initials** _____

Draping will be used during the massage session unless other wise agreed to by both client and therapist. "Draping" means your body will be modestly covered by a sheet during massage. **Initials** _____

If the client is uncomfortable for any reason, the client may ask to end the massage session, and the session will be ended. **Initials** _____

Client signature: _____ Date: _____

(Parent or Guardian if under the age of 17)

Therapist signature: _____ Date: _____

LIC# MT045974

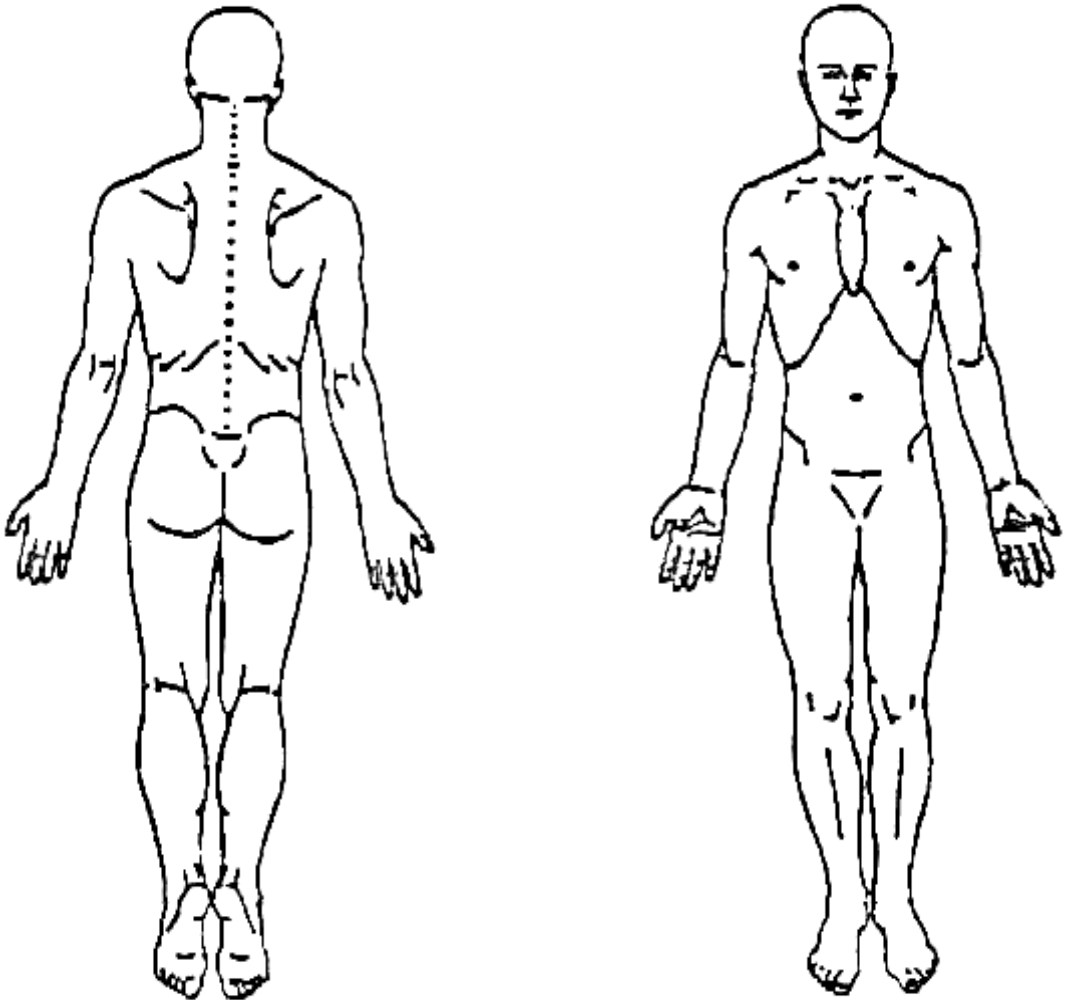
To be completed by the massage therapist:

Type of Massage Techniques to be used:

- ☐ Swedish Massage Therapy
- ☐ Pain Relief & Trigger Point
- ☐ Hot Stone
- ☐ Deep Tissue
- ☐ Prenatal Massage
- ☐ Sports Massage

Parts of the body to be massaged: (including indication and contraindications)

Please indicate where you pain is located with an X



Intake Form Addendum

To best protect your health and the health of others, please fill out this form before each massage and bodywork session. Thank you!

Name _____ Date _____

Have you been tested for COVID-19? If yes, what type of test did you have?

When was your test?

What were the results?

Have you been inplaces with a high infection rate within the last two weeks (e.g., state-designated "hotspots?)? If yes, please explain.

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

- ☐ Fever
- ☐ Chills
- ☐ Cough
- ☐ Sore throat
- ☐ Diarrhea, digestive upset
- ☐ Nasal, sinus congestion
- ☐ Loss of sense of taste or smell
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Sudden onset of muscle soreness (not related to a specific activity)
- ☐ Rash or skin lesions (especially on the feet)

Do you have any new discomfort with exertion or exercise? ☐ **Y** ☐ **N**

I declare that the information provided above is true and accurate to the best of my knowledge.

Client signature: _____ Date: _____