|  |  |  |  |
| --- | --- | --- | --- |
|  | | Today’s Date |  |
| Name |  |  |  |
| Street Address |  |  |  |
| City/State/Zip |  |  |  |
| Home Phone |  | Mobile/Work |  |
| Date of Birth |  | Occupation |  |
| Emergency Contact |  | Phone Number |  |
| e-mail address |  |  |  |

May I contact you regarding scheduling and confirming appointments and occasional updates regarding my practice via email. Yes / No (circle one) If no, how would you prefer to be contacted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your reason for receiving a therapeutic massage today?

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Please list any health conditions you are currently experiencing?

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Please list any **medications or supplements** you are currently taking (prescriptions, pain relievers, herbal remedies) or provide a list to your LMT to attached to this document. You are responsible for updating your LMT when you start new medication(s).

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Have you had any **surgeries, accidents, injuries** or **allergies** to scents, lotions or detergents? Yes / No (circle one)

If yes, please list what, when and where: *(injuries as far back as childhood can be relevant, please list all)*

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Are you **CURRENTLY** or have you **PREVIOUSLY** experienced any of the following (please check all that apply)…

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| --- | --- | --- | --- | --- | --- |
| *current* | *past* | *condition* | *current* | *past* | *condition* |
| 🞏 | 🞏 | Pain, muscular, nerve or other  Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | Tendonitis, bursitis: Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 | 🞏 | Headache | 🞏 | 🞏 | Whiplash, concussion |
| 🞏 | 🞏 | Chronic Fatigue Syndrome, Fibromyalgia | 🞏 | 🞏 | Pregnancy: current week of pregnancy \_\_\_\_\_or # of pregnancies \_\_\_\_\_\_\_\_\_  Natural or C-Section? |
| 🞏 | 🞏 | Weakness, numbness or tingling. Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | Abdominal or Pelvic surgery  Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 | 🞏 | Sciatica | 🞏 | 🞏 | Heart Disease, Stroke or blood clots |
| 🞏 | 🞏 | Sprain (ligament tear): Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | High or low blood pressure |
| 🞏 | 🞏 | Strain (muscle/tendon tear):  Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | Poor circulation |
| 🞏 | 🞏 | Osteoporosis/penia | 🞏 | 🞏 | Varicose veins |
| 🞏 | 🞏 | Spinal disc problems | 🞏 | 🞏 | Diabetes |
| 🞏 | 🞏 | Scoliosis | 🞏 | 🞏 | COPD, pneumonia |
| 🞏 | 🞏 | Spasms, cramps | 🞏 | 🞏 | Cancer: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 | 🞏 | Stiff or painful joints | 🞏 | 🞏 | Asthma |
| 🞏 | 🞏 | Sprain (ligament tear): Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | MS or other autoimmune disease  Please specify?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 | 🞏 | TMJ, jaw pain | 🞏 | 🞏 | PTSD |
| 🞏 | 🞏 | Broken Bones  Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 | 🞏 | Depression |
| 🞏 | 🞏 | Swelling or Lymphedema | 🞏 | 🞏 | Sexual Abuse/Rape |
| 🞏 | 🞏 | Arthritis | 🞏 | 🞏 | COVID-19 When? |
| 🞏 | 🞏 | Thoracic Outlet Syndrome | 🞏 | 🞏 | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Contract for Care**

\_\_\_\_\_\_\_\_\_\_\_(initial) I will arrive on time for my appointment. If I am late for my appointment, the session will still end at

the original time. I understand that I will need to leave the treatment room at the end of my appointment to allow my therapist to prepare, change PPE and clean the room for the next client.

\_\_\_\_\_\_\_\_\_\_\_(initial) If I fail to show up for an appointment without canceling within 24 hours of the scheduled appointment

time, I will be charged full price for the missed session (exceptions include illness, injury or family emergency.)   
Changes in work schedule is not exempt.

\_\_\_\_\_\_\_\_\_\_\_(initial) Payment is due at time of service. Rates are $XX/hour and $XX/hour & a half. Rates may be increased

in the future, but you will be informed of any changes. Check, cash and MC/Visa are accepted. Receipts will be provided on request.

\_\_\_\_\_\_\_\_\_\_\_(initial) I am responsible for reporting any and all health conditions, past and present, to <name> in order

to receive the best care. Failure to disclose all health condition on this health history and before any

future appointments can result in inappropriate, contraindicated treatment or infection risk.

\_\_\_\_\_\_\_\_\_\_\_(initial) I understand that some conditions require treatment of muscles, fascia, tendons, ligaments and joints

that are located in the area of the inner thigh, hips/gluteals, pelvis, abdomen and chest. My LMT will discuss these areas as part of the overall plan prior to treatment and answer any questions before, during or after your session. These areas will only be exposed in accordance with massage draping laws of Washington State and with your verbal consent. You are encouraged to communicate with your LMT if you ever become uncomfortable and want specific work, or the entire treatment, to stop.

Your Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_