Treatment Consent / COVID-19 Update
We have updated our intake form. All current and new clients must complete this form prior to receiving any services.

Personal Info

Name ______________________________ Phone ______________
Address ____________________ City/State/Zip ______________
Email ____________________________ DOB ______________
Occupation/Employer ____
Primary Care Provider ______________________________ Phone ________
Emergency Contact ______________ Relationship __________ Phone ________

Massage History / Treatment Information

Have you ever received a professional massage? Yes ☐ No ☐

What results do you want from your sessions? ______________________________

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Please check any areas of your body where you prefer not to receive massage:

Head ☐ Face ☐ Neck ☐ Arms ☐ Chest ☐ Abdomen ☐ Back ☐ Buttocks ☐ Legs ☐ Feet ☐
Other ☐ ____

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Are you currently seeing a healthcare practitioner? Yes ☐ No ☐

If Yes, please describe: ____

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List stress Reduction and Exercise Activities. Please include frequency. ______________

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List current Medications, Herbals & Supplements and reason for use. Please Include OTCs such as Aspirin, Ibuprofen, Claritin, etc. ______________________________

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Previous History

Surgeries (Include year and treatment received) ______________________

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Accidents (Include year and treatment received) ______________________

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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 symptoms, sore throat, 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☐

Health History

Musculoskeletal:
Bone or Joint Disease☐ Tendinitis / Bursitis☐ Broken / Fractured Bones☐ Arthritis / Gout☐
Jaw Pain / TMD☐ Lupus☐ Sprains / Strains☐ Low Back, Hip, Leg Pain☐ Neck, Shoulder, Arm Pain☐
Headaches, Head Injuries☐ Spasms/Cramps☐
Other: ______________________

Circulatory:
Heart Condition☐ Varicose Veins / Phlebitis☐ Blood Clots☐ High / Low Blood Pressure☐
Lymphedema☐ Thrombus / Embolism☐
Other: ______________________

Respiratory:
Breathing Difficulty / Asthma☐ Emphysema☐ Sinus Problems☐ Allergies☐
Other: ______________________

Nervous:
Herpes / Shingles☐ Numbness / Tingling☐ Pinched Nerve☐
Other: ______________________

Reproductive:
Pregnant☐ Ovarian / Menstrual Problems☐ Prostate☐ PMS☐
Other: ______________________

Skin:
Allergies☐ Rashes☐ Athletes Foot☐ Herpes / Cold Sores☐ Warts☐
Other: ______________________

Digestive:
Constipation☐ Gas / Bloating☐ Diverticulitis☐ Irritable Bowel Syndrome☐ Ulcers☐
Other: ______________________

Other:
Cancer / Tumor☐ Diabetes☐ Chronic Fatigue☐ Chronic Pain☐ Eating Disorders☐
Sleep Disorders☐ Bladder / Kidney Ailment☐ Drug / Alcohol Addiction☐
Caffeine / Tobacco Addiction☐ Migraines / Headaches☐ Anxiety / Stress Syndrome☐
Depression☐ Contact Lenses☐

Consent and Contract for Care

It is my choice to receive massage therapy or yoga, and I give my consent to receive treatment. I have completed this form to the best of my knowledge and will inform the massage therapist or yoga instructor or any changes in my physical health. I understand that massage therapist and yoga instructors can not diagnose illness, disease, or any other medical, mental, or emotional disorder. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I realize that the treatment is being given for the well being of my body, mind and spirit. This includes stress reduction, relief from muscular tension, spasm or pain, also for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my wellbeing is compromised. I acknowledge that massage and yoga are not substitutes for medical examinations or diagnosis; I am responsible for consulting a qualified physician for any physical ailments that I have. I understand that massage therapy and yoga is a therapeutic health aide and is non-sexual.

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By agreeing to this statement, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Your Signature: ______________________________

Date: ______________________________

Parent / Guardian: ______________________________

Date: ______________________________