Massage Therapy Medical History and Consent for Treatment

Name:_____Date:_____

Pronouns: **She/Her He/Him They/Them** DOB:_____

Email:_____ _____ Phone:_____

Address: _____

Occupation:_____ Emergency Contact: _____

Relation: _____ Phone:_____

How did you hear about Little Moon? _____

Please list any regular physical activity/exercise:_____

Have you received massage before? **Y** or **N** When was your last massage? _____

What depth of pressure do you prefer? **Light Medium Firm** Do you feel well today? **Y** or **N**

How would you rate your pain level today (**1-10**)? _____ How would you rate your stress level today (**1-10**)? _____

Are there any areas you'd like to focus on?_____._____

Are there any areas you **DO NOT** want touched (hair, face, glutes, etc.)? _____

What are your goals for this session? _____

Please list any **recent or relevant** Surgeries/Accidents/ Illnesses: _____

_____

Please list all medications (**include Recreational, OTC, Rx, Herbs & Supplements**): _____

_____

Do you have any of the following conditions that may impact our session? (circle all that apply)

fever infection contagious disease blood clots congestive heart failure pitting edema

Check all that apply:

- ○ Skin Sensitivities
- ○ Allergies (please list on back)
- ○ Open Cuts/Sores/Lesions
- ○ Fresh/Painful Bruises
- ○ Muscle Tension & Pain
- ○ Joint Stiffness & Pain
- ○ Joint Replacement:_____
- ○ Tendonitis
- ○ Arthritis
- ○ Neck Pain
- ○ Shoulder Pain: Left ☐ Right ☐
- ○ Bulging/Herniated Spinal Disc(s)
- ○ Scoliosis
- ○ Low Back Pain
- ○ Hip Pain Left ☐ Right ☐
- ○ Sciatica Left ☐ Right ☐
- ○ Knee Pain Left ☐ Right ☐
- ○ Foot Pain Left ☐ Right ☐
- ○ Plantar Fasciitis Left ☐ Right ☐
- ○ Pins/Screws/Implants
- ○ Frequent Joint Dislocation
- ○ Hypermobility
- ○ Connective Tissue Disorders
- ○ Asthma/Reactive Airway
- ○ Sensitivity to Smells
- ○ Prefer **NO** Essential Oils
- ○ Sensitivity to Heat
- ○ Sensitivity to Cold
- ○ POTS
- ○ Dysautonomia
- ○ Sleep Apnea
- ○ Neurological Disorders
- ○ Migraines
- ○ Frequent Headaches
- ○ Seizures/Epilepsy
- ○ Numbness/Tingling
- ○ High Stress Levels
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks
- ○ Psychological Trauma
- ○ PTSD/C-PTSD
- ○ Autism/ASD
- ○ Sensory Processing Disorder
- ○ Endometriosis
- ○ Fibromyalgia
- ○ Autoimmune Disorders
- ○ HIV/AIDS
- ○ Heart Problems
- ○ Circulation Problems
- ○ Varicose Veins
- ○ History of Blood Clots/DVT
- ○ Pacemaker
- ○ Blood Pressure: High ☐ Low ☐
- ○ Thyroid/Endocrine Dysfunction
- ○ Cancer: _____
- ○ Lymphedema
- ○ Diabetes Type I ☐ Type II ☐
- ○ Insulin Pump
- ○ Bladder/Bowel Incontinence
- ○ External Catheter/Ostomy Bag
- ○ Hard of Hearing/Hearing Aid

Are you interested in using topical CBD for pain/inflammation?

Yes ☐ No ☐

Are you under the influence of illicit drugs and/or alcohol?

Yes ☐ No ☐

Are you pregnant?

Yes ☐ No ☐

If Yes, How many weeks?_____

Have you had any complications?____

_____

_____

Have you ever had a positive COVID-19 test? Yes ☐ No ☐ Are you vaccinated against COVID-19? Yes ☐ No ☐
Have you experienced "long COVID" symptoms? _____ _____
Use this space add any details or list any other conditions, medications, or concerns that may impact our session today:
_____
_____
_____

Consent for Treatment

- I understand that while massage therapy is an overwhelmingly safe treatment, common risks include: bruising, muscle soreness, over-stretching, burns from hot stone therapy, and skin sensitivities to aromatherapy and massage lubricants. I understand that risks are drastically minimized by accurate reporting of my health information and good communication with the licensed massage therapist (LMT).
- Because massage should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and answered all questions honestly to the best of my knowledge. I agree to keep the LMT updated as to any changes in my medical profile and understand that there shall be no liability on the part of the LMT *s*hould I fail to do so.
- If I experience pain or discomfort during this session for any reason, I will immediately inform the LMT so that the pressure and/or manipulations may be adjusted to my level of comfort.
- I acknowledge that both the LMT and I have the right to terminate the massage session at any time.
- I understand that the LMT will ask for verbal consent before using any CBD or essential oil products topically on my skin. It is my responsibility to make the LMT aware of any allergies or sensitivities I may have to these products. I understand that every person responds to topical CBD products differently. The CBD used during the session is hemp-derived and contains less than 0.3% THC as required by law. I understand that the LMT does not claim to use topical CBD to cure, treat, or eliminate any condition I may be experiencing. I will consult a physician/pharmacist with any questions related to medication use while regularly using CBD products.
- I understand that LMTs 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 should be construed as such. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment.
- I understand that my health records belong to me and I can request a copy at any time. The LMT will keep client communication and information confidential and will not share client information without the client's written consent, within the limits of the law. Records are kept for a minimum of 4 years as required by WV state law.
- Because my appointment time is reserved exclusively for me, at least 6 hours' notice of cancellation is required. Should I fail to notify the LMT in time, I understand that will be charged 50% of the fee for scheduled session. Exceptions will be made for emergencies at the LMT's discretion.
- I understand that Little Moon Massage & Wellness has a "No Hateful Conduct" policy. Hateful conduct is defined as *intimidation and hate against people on the basis of race, ethnicity, national origin, sexual orientation, gender, gender identity, religious affiliation, age, disability, or serious disease*. Should I fail to abide by this policy, the LMT reserves the right to terminate the session and all future sessions, and I will be held liable for payment of the scheduled appointment.
- I understand that *any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and all future sessions, and I will be liable for payment of the scheduled appointment*.

Understanding all of this, I give my consent to receive care.

Name of Client: _____ Date: _____

Signature of client or Guardian: _____

LMT Signature:_____