

Medical History and Treatment Consent

Name: _____ Date: _____

Preferred personal pronouns: **She/Her He/Him They/Them** Preferred contact method: **Phone Text Email**

Email: _____ DOB: _____

Address: _____

Phone: _____ OK to send appointment reminders via text/email? **Y or N**

Occupation: _____ Emergency Contact: _____

Relation: _____ Phone: _____

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 (scalp, face, glutes, etc.)? _____

What are your goals for this session? _____

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

Please list all medications (**include 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Muscle Tension & Pain | <input type="checkbox"/> Allergies (please list):
_____ | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Hypermobility | <input type="checkbox"/> _____ | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Joint Stiffness & Pain | <input type="checkbox"/> Frequent Sinus Problems | <input type="checkbox"/> History of Blood Clots/DVT |
| <input type="checkbox"/> Frequent Joint Dislocation | <input type="checkbox"/> Open Cuts/Sores/Lesions | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Fresh/Painful Bruises | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pins/Implants | <input type="checkbox"/> Connective Tissue Disorders | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Sensitivity to Smells |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Prefer NO Essential Oils |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Bulging/Slipped Spinal Disc(s)
_____ | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Autism/ASD | Are you interested in using topical
CBD for pain/inflammation?
Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Sensory Processing Disorder | Are you under the influence of illicit
drugs and/or alcohol?
Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Thyroid/Endocrine Dysfunction | Are you pregnant?
Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Cancer | If Yes, How many weeks? _____ |
| <input type="checkbox"/> High Stress Level | <input type="checkbox"/> Lymphedema | Have you had any complications? _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Insulin Pump | _____ |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Psychological Trauma | <input type="checkbox"/> Bladder/Bowel Incontinence | |
| <input type="checkbox"/> Skin Sensitivities | <input type="checkbox"/> External Catheter/Ostomy Bag | |
| | <input type="checkbox"/> Heart Problems | |

Use this space to 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 should 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 I 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: _____