**Medical History and Treatment Consent**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:**

* Muscle Tension & Pain
* Hypermobility
* Joint Stiffness & Pain
* Frequent Joint Dislocation
* Joint Replacement
* Pins/Implants
* Tendonitis
* Bursitis
* Arthritis
* Neck Pain
* Low Back Pain
* Bulging/Slipped Spinal Disc(s)
* Scoliosis
* Sciatica
* Plantar Fasciitis
* Numbness/Tingling
* Frequent Headaches
* High Stress Level
* Depression
* Anxiety
* Panic Attacks
* Psychological Trauma
* Skin Sensitivities
* Allergies (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Frequent Sinus Problems
* Open Cuts/Sores/Lesions
* Fresh/Painful Bruises
* Connective Tissue Disorders
* Migraines
* Fibromyalgia
* Autoimmune Disorders
* HIV/AIDS
* Neurological Disorders
* Seizures/Epilepsy
* Autism/ASD
* Sensory Processing Disorder
* Thyroid/Endocrine Dysfunction
* Cancer
* Lymphedema
* Diabetes
* Insulin Pump
* Hepatitis
* Bladder/Bowel Incontinence
* External Catheter/Ostomy Bag
* Heart Problems
* Circulation Problems
* Varicose Veins
* History of Blood Clots/DVT
* Pacemaker
* High Blood Pressure
* Low Blood Pressure
* Asthma
* Breathing Problems
* Sensitivity to Smells
* Prefer **NO** Essential Oils
* Sensitivity to Heat
* Sensitivity to Cold

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 If yes, please list approximate date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you vaccinated against COVID-19? Yes No How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received a COVID-19 booster shot? Yes No Not yet, but I plan to

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 *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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_