Healing Connection Massage/Robin Albright, LMT
Confidential Client Information and Health History

Name:			Date:
Address:	City:	State:	Zip:
Phone #: Home:	Work:	Cell:	
Date of Birth: Age:	Sex: ☐ Male ☐ Female		Email:
Emergency Contact:			Phone:
Referred By:		Do you have a prescription for medical massage?	
Occupation:		Is this your first professional massage?	

Are you currently under the care of a physician? Name: _____
Phone: _____

Are you currently under the care of a Chiropractor or Physical Therapist? Explain:
_____

Current Medications:	Taking for:	Allergies:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Are you allergic to any scents or essential oils?
_____	_____	_____
_____	_____	_____

Injuries or Accidents within the past 5 years:	Surgeries within the past 5 years:
_____	_____
_____	_____
_____	_____
_____	_____
_____	

CONSENT FOR CARE

☐ I understand that my Licensed Massage Therapist is <u>not</u> a licensed MEDICAL healthcare provider and that massage/bodywork is not a substitute for medical care, medical examination, or diagnosis. I have stated all my known medical conditions and will inform my therapist of any change in my health status.

☐ I understand that there is no implied or stated guarantee of success or effectiveness for massage/bodywork sessions. It is my choice to receive massage/bodywork and I give my consent for massage/bodywork.

☐ I have read the Clinic Policies and Payment Policies document and agree to abide by them. I understand the different pricing for the different levels of service provided by Robin Albright, LMT.

☐ I understand that the client – therapist relationship will be held in strict confidence.

Client Name: _____

Client Signature: _____ Date: _____
(Parent/Guardian if under 18 years of age)

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Are you currently experiencing any of the following conditions?

____Flu or Cold ____Inflammation ____Fever ____Infection ____Contagious Disease

Please check (√) any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL
__ Fibromyalgia
__ Spasms/Cramps
__ Sprains/Strains
__ Osteoporosis
__ Postural Deviations
__ Gout
__ Osteoarthritis/Rheumatoid Arthritis
__ TMJ Dysfunction
__ Cysts
__ Bursitis
__ Plantar Fascitis
__Tendonitis
__ Torticollis
__ Whiplash Syndrome
__ Carpal Tunnel Syndrome
__ Sciatica
__ Thoracic Outlet Syndrome
__ Headache
__ Leg Pain
__ Arm Pain/Shoulder Pain
__ Low Back Pain
__ Mid Back Pain
__ Hip Pain
__ Other

RESPIRATORY
__ Asthma
__ Dizziness
__ Pneumonia
__ Sinusitis
__ Trouble Breathing
__ Emphysema
___ Other

CIRCULATORY
___Anemia
___Hemophilia
___High Blood Pressure
___Low Blood Pressure
___Raynaud's Disease
___Varicose Veins
___Heart Condition
___Blood Clots/Phlebitis
___Diabetes
___Other

DIGESTIVE
___Ulcers
___Irritable Bowel Syndrome
___Colitis
___Gallstones
___Hepatitis
___Crohn's Disease
___Diarrhea
___Gas/Bloating
___Indigestion
___Other

SKIN
___Athletes Foot
___Fungal Infections – Acne
___Dermatitis/Eczema
___Impetigo
___Open Wound or Sore
___Psoriasis
___Rashes
___Warts/Moles
___Other

NERVOUS SYSTEM
__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuritis
__ Spinal Cord Injury
__ Stroke
__ Trigeminal Neuralgia
__ Seizure Disorders
__Numbness/Tingling
__ Other

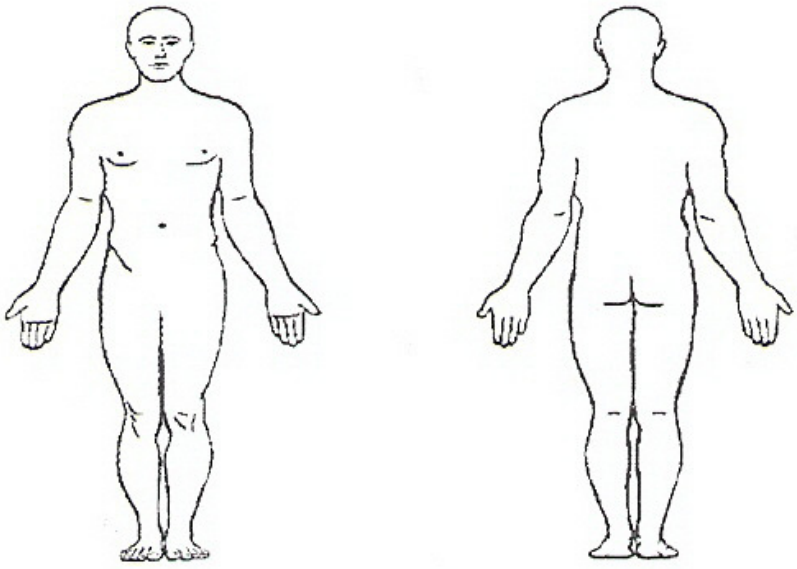
OTHER
__ Cancer
__ Sleep Apnea
__ Anxiety/Panic Attacks
__ PMS
__ Physical/Emotional Abuse
__ Grief Process
__ Insomnia
__ Substance Abuse
__ Pregnancy
__ Chronic Fatigue
__ Edema
__ HIV/AIDS
__ Lupus
__ Kidney Disease
__ Bladder Infection
__ Postoperative Situation
__ Edema
__ Other

The above information is true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my massage therapist to any physical, mental or emotional changes that occur with my health.

Signature: _____ Date: _____
(Parent/Guardian if under 18 years of age)

Healing Connection Massage/Robin Albright, LMT
Confidential Client Treatment and Pain Assessment

Please mark any areas of discomfort:



Do you have any chronic, ongoing pain that you deal with on a regular basis? ☐ Yes ☐ No

Explain: _____

_____

_____

What activities cause this pain or make it worse?

_____

_____

_____

What is your primary goal for your massage/bodywork session? Check all that apply.

☐ Pain Management ☐ Reduce Stress ☐ Relaxation

☐ Relieve Discomfort ☐ Maintain Health ☐ Other:_____

Are you aware of any areas of your body where you seem to hold tension? ☐ Yes ☐ No

If so, what are the locations: _____

_____

_____

The above information is true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my massage therapist to any physical, mental or emotional changes that occur with my health.

Signature: _____ Date: _____

(Parent/Guardian if under 18 years of age)

Massage Therapist: _____ Date: _____

Healing Connection Massage/Robin Albright, LMT
Massage Therapy Informed Consent

Please take a moment to carefully read the following information and sign where indicated.

If you have a medical condition or specific symptoms, massage therapy may be problematic for you. A referral from your primary health care provider may be required prior to treatment being provided; you may wish to contact your primary health care provider to verify that massage is indicated in your situation.

I understand that the treatment I receive is for the basic purpose of relaxation and relief of muscular tension.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, I understand that it is my responsibility to IMMEDIATELY inform the massage therapist, so that the massage can be terminated or the strokes and pressure can be adjusted to a level of comfort.

I further understand that massage therapy is not a substitute for medical examination, diagnosis, and treatment. I understand that the Massage Therapy Scope of Practice, Ohio Revised Code 4731-1-05 does not include any spinal or skeletal adjustment, diagnosis or prescription to treat any physical or mental illness, and that nothing discussed is a replacement for medical advice.

1. Prior to massage, remove all jewelry. Pull long hair back with a clip.
2. Please provide feedback as to pressure (deeper or lighter) and discuss painful or ticklish areas of your body.
3. Feel free to ask questions about the procedures. The massage therapy provider is well trained, ethical, and professional, and will be happy to make you feel well informed and comfortable.
4. Keep all changes to the medical health profile updated; it is especially important to report any changes in health or medications, as massage may be contraindicated in new situations.
5. Any illicit or sexually suggestive remarks or advances will result in immediate termination of the treatment.

Client's Signature:_____ Date:_____

Therapist's Signature:_____ Date:_____