Massage Therapy Health Form

Total Zen massage & skin

Full Name	DOB	Age
Email	Phone	
Address		
City	State	Zip
Occupation	Employeer	
Emergency Contact	Relationship	Phone

Are you taking any medication? No ☐ Yes ☐ If yes, please list name and use _____

_____

Are you currently pregnant? No ☐ Yes ☐ If yes, how far along? Any high risk factors? _____

_____

Do you suffer from chronic pain? No ☐ Yes ☐ If yes, please explain _____

Have you had any orthopedic injuries? No ☐ Yes ☐ If yes, please list _____

_____

Have you had any surgeries? No ☐ Yes ☐ If yes, please list _____

_____

Please indicate any of the following that apply to you:

- ☐ Allergies
  - ☐ Food
  - ☐ Seasonal
  - ☐ Other _____
- ☐ Arthritis _____
- ☐ Back/ Neck Tension
- ☐ Blood Clots
- ☐ Carpel Tunnel
- ☐ Cerebral Palsy
- ☐ Circulatory Problems
- ☐ Diabetes _____
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ High/Low Blood Sugar
- ☐ Joint Pain
- ☐ Kidney Dysfunction
- ☐ Knee Pain
- ☐ Sinus Problems
- ☐ Varicose Veins
- ☐ Knee Problems
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Numbness
- ☐ Open Sores/Wounds
- ☐ Osteoporosis
- ☐ Sciatica
- ☐ Skin Rashes
- ☐ Shoulder/Rotator Cuff
- ☐ Sprains/Strains
- ☐ Stress
- ☐ Stroke
- ☐ Tendonitis
- ☐ TMJ

Have you had a professional massage before? No ☐ Yes ☐

What type of massage are you seeking?

☐ Swedish/Relaxation ☐ Therapeutic ☐ Deep Tissue ☐ Other

What pressure do you prefer?

☐ Light ☐ Medium ☐ Firm ☐ Deep

Are there any area's (face, feet, abdomen, etc.) that you do not want massaged? No ☐ Yes ☐ _____

What are your goals for this session? _____

LMT NOTES:

By signing below you agree to the following, I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Clients Name (printed) _____ Signature _____ Date _____

Client Consent Form

I hereby give consent and authorize **Total Zen Massage & Skin** to provide massage therapy to me.

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

_____ I understand that massage therapy may provide benefits for certain conditions which may include relief of muscular tension, relaxation, improvement of circulation, reduction in the symptoms of stress-related conditions and provision of general wellbeing, but results are no guaranteed.

_____ I understand that the side effects of massage therapy may include muscle soreness, mild bruising, increased areas of pain, swelling and light-headedness amongst other possible temporary outcomes.

_____ I will advise the Therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly. I will not hold my Therapist responsible for any pain or discomfort during or after my session.

_____ I understand that draping will be used to ensure my privacy and that this massage is totally therapeutic and non-sexual in nature.

_____ I am aware that the Therapist is not qualified to diagnose illnesses, prescribe medication, or physically perform spinal and skeletal adjustments.

_____ The Therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the Therapist performs.

_____ I understand that any intoxication, sexual innuendos, language and/or behavior made my me will not be tolerated and will result in immediate termination of the session with no refund.

_____ The information I have provided about my medical history is accurate to the best of my knowledge, including all known allergies and/or prescription drugs/ products I am currently ingesting or using topically.

<u>Before each treatment:</u>

- Tell your therapist about any changes in your health since your last visit
- Please remove all jewelry, exception of wedding bands.
- Ask your therapist if it is best to bind long hair up on your head

<u>Throughout your visit:</u>

- Please ask questions about the procedures. Your therapist will be happy to keep you informed and comfortable
- Always inform your therapist immediately upon any pain or discomfort.

I confirm that I am at least 18 years of age and by signing this Consent Form, I agree to waive all liability towards my Therapist and **Total Zen Massage & Skin** for any injury or damages incurred due to any misrepresentation of my medical history.

Clients Name (printed)_____ Signature _____ Date _____

PARENTAL CONSENT

I acknowledge that my child is under the age of 18 years of age and by signing this Parental Consent Form, I am agreeing to have **Total Zen Massage & Skin** perform massage therapy on my child/dependent.

Parent/Guardian _____ Signature _____ Date _____

Total Zen
massage & skin

Cancelation Policies

We understand that unanticipated events happen occasionally in everyone's life. It is our desire to be effective and fair to all clients. Your care and treatment is a priority to us and we strive to provide excellent care to you and all of our clients but we also ask that you respect our specialist's time and expertise as well.

In our efforts to be consistent with this, we have a Cancelation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and our specialist's time.

Our policy is as follows:

You may cancel an appointment at no charge 48 hours before your appointment date/time.

If the client misses an appointment without contacting us, it is considered a "No Show" appointment. If you are late for your appointment, your session will be shortened accordingly as we will have another session to prepare for after yours. Additionally, if the client is more than 15 minutes late for an appointment it will be considered a "No Show" appointment and need to be rescheduled.

After a client receives one (1) "No Show" appointment, any more after that will result in a full-price charge for that visit.

We require a valid credit card to put on file to reserve your appointment. The card will only be charged if you fail to show up for your appointment after already receiving one (1) "No Show" appointment. If you do not wish to provide a credit card, we cannot reserve your appointment. You may chance walking in but, we cannot guarantee that the time you want will be available.

If you have any questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

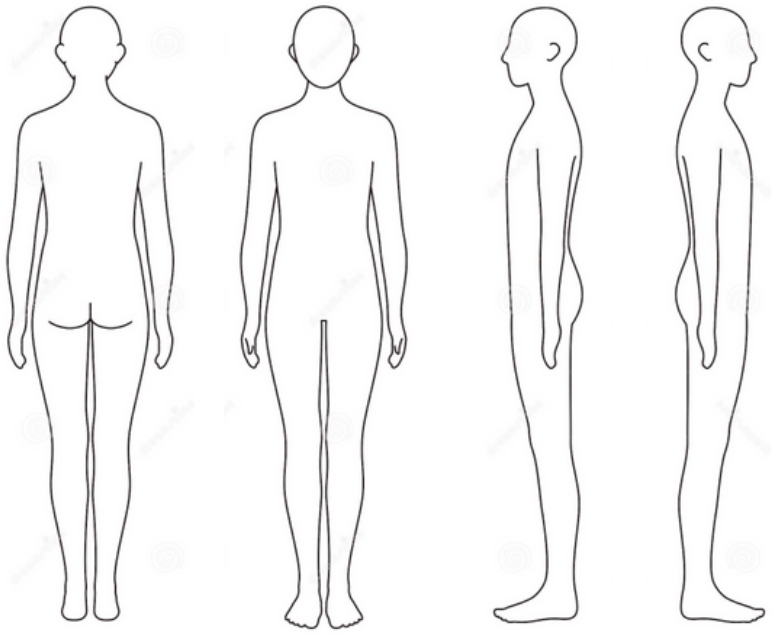
I have read and understand the Cancelation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to these terms

I, _____ , have received the copy of the Cancelation Policies.

Name (Printed) _____ Signature _____ Date _____

OFFICE USE ONLY / SOAP Notes

Name	DOB
Therapist	Date



BACK FRONT LEFT RIGHT

REASONS FOR TREATMENT

- ☐ Relieve Stress
- ☐ Promote Relaxation
- ☐ Sleep Better
- ☐ Reduce Muscle Tension
- ☐ Relieve Tension Headache
- ☐ Enhance Exercise Performance
- ☐ Manage Lower Back Pain
- ☐ Help Chronic Neck Pain
- ☐ Relieve Postoperative Pain
- ☐ Reduce Osteoarthritis Pain
- ☐ Reduce Rheumatoid Arthritis Pain
- ☐ Increase Range of Motion
- ☐ Other: _____

_____

TECHNIQUES USED DURING MASSAGE:

NOTES: