



MJU Massage
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COVID-19 SELF MONITORING CHECKLIST

With the ever-changing nature of COVID-19 and MONKEYPOX, there remains the possibility of exposure. Since MJU Massage has started seeing clients again, I also understand that is risk in doing so and can lead to additional exposure to COVID-19 or MONKEYPOX. Therefore I have established guidelines for any client to enter the studio. You may continue to come as long as you are able to honestly answer **NO** to the following questions. However, Please remember, if you develop any of the symptoms below, **STAY HOME**.

SYMPTOMS OF INFECTION

	<u>YES</u>	<u>NO</u>
COVID19		
Fever of 100.4 or higher	_____	_____
Cough	_____	_____
Headache	_____	_____
Sore Throat	_____	_____
Shortness of Breath	_____	_____
Fatigue	_____	_____
Loss of taste or smell	_____	_____
Unexplained body aches	_____	_____
or who may have symptoms with COVID-19	_____	_____
MONKEYPOX		
Fever	_____	_____
Headache	_____	_____
Muscle aches	_____	_____
Backache	_____	_____
Swollen lymph nodes in your throat or groin	_____	_____
Chills and exhaustion	_____	_____
Lesions on or near the anus	_____	_____
Lesions on the genitals	_____	_____
Lesions inside the throat	_____	_____

If you answered YES to any of the above, then it is not safe to enter the building or be in contact with others. Please do not come into office.

In addition to self-monitor your symptoms, please continue to:

- Wash your hands often, and for at least 20 seconds at a time.
- Avoid touching your face.
- Cover your coughs and sneezes with the sleeve of your shirt or coat.
- Call your doctor if you have a fever, cough, shortness
- Rash or lesions

Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

**The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.**

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () dentures () a hearing aid () ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____

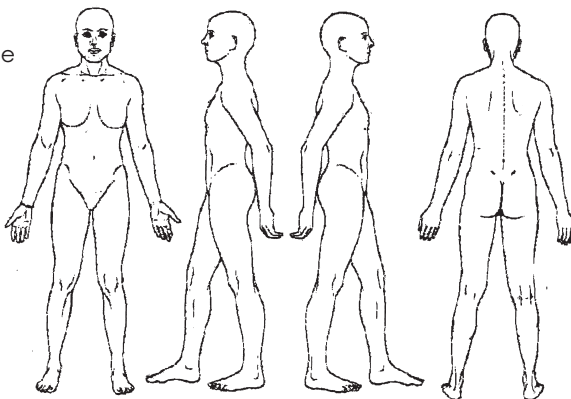
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
muscle tension () anxiety () insomnia () irritability () other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain
or other discomfort? Yes No
If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

Circle any specific areas you would like the
massage therapist to concentrate on
during the session:



Medical History

**In order to plan a massage session that is safe and effective,
I need some general information about your medical history.**

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No

If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Marc Udell, LMT
MJU Massage
Client Policy Statement &
Informed Consent Agreement

Scope of practice includes the following:

Swedish based deep tissue massage, stretching of muscle groups as needed, trigger point therapies needed.

Benefits, limitations and contraindications:

The benefit of regular massage therapy is relaxation, better circulation of blood flow through the body, and elimination of toxins in the lymphatic system, and a greater amount of oxygen flowing through blood stream to the body organs. However this type of massage is not for everyone. People with uncontrolled high blood pressure, are pregnant, have sun burn, skin rashes, should consult with physician prior to scheduling an appointment.

The need of current medical information for client:

It is extremely important that I have current medical information about you. Having up to date information regarding prescription drug information, illness, injuries, etc. will help me provide the best care and massage practice that is right for each client.

Fee Structure:

- Hourly rate is \$100.00 per hour 60, 90 and 120 minute sessions available. These rates do not include body grooming or salt scrub as they are priced differently.
- There is a 20% discount offered with the purchase of a package of 5 sessions.
- These discounts are only available when package is paid in full up front and are, not refundable.
- packages are purchased on a use or loose basis and are good for one year from date of purchase.
- Payment for services may be paid for in cash, Zelle or credit card, checks accepted on a case by case basis.
- Insurance is not accepted I am not set up with insurance companies.
- Invoices can be provided upon request.

Hours of Service ? Confidentiality & Etiquette:

- The hours that services are available 10am to 7pm Monday through Thursday, 10am to 6pm Friday, 10am to 4pm Saturday, Closed on Sunday.
- If client is going to be late to an appointment it is expected that client will call or text as soon as they know they will be running late.
- There is a possibility that the client may need to reschedule if there is a conflict due to their lateness.
- If client needs to cancel appointment There is a minimum 24 hour advance notice of cancelation.
- No Show and cancelation with less than 24 hours notice is subject to payment in full from client as session generally can-not be rebook by another client at that point.
- Clients are expected to have good hygiene meaning freshly showered. Clients with poor hygiene will be asked to reschedule and will be charged for the session. If this becomes a problem client will be asked to find another massage therapist.
- No client will be provided massage services if they are intoxicated (alcohol, drugs or any other substance). deemed to be safe for massage.
- It is recommended that client does not eat a meal less than two hours prior to massage as having a massage right after eating can have an adverse effect on the digestive process.

Client Signature

Date

Client Name