Medical Information / Consent to Treatment Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnant Y / N

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had a massage before? Y / N

Are you taking any medications? Y / N Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following:

|  |  |  |
| --- | --- | --- |
| \_\_\_\_ arthritis, bursitis  | \_\_\_\_ cancer | \_\_\_\_ headaches |
| \_\_\_\_ joint replacement, pins | \_\_\_\_ diabetes | \_\_\_\_ asthma |
| \_\_\_\_ phlebitis | \_\_\_\_ stress, tension | \_\_\_\_ allergies to oils |
| \_\_\_\_ colitis | \_\_\_\_ stabbing pains | \_\_\_\_ decreased range of motion |
| \_\_\_\_ blood clots | \_\_\_\_ accident, describe | \_\_\_\_ high blood pressure |
| \_\_\_\_ low blood pressure | \_\_\_\_ broken bones | \_\_\_\_ epilepsy or seizures |
| \_\_\_\_ abdominal pain | \_\_\_\_ varicose veins | \_\_\_\_ wear prosthesis |
| \_\_\_\_ whiplash | \_\_\_\_ allergies, describe | \_\_\_\_ loss of appetite |
| \_\_\_\_ constipation | \_\_\_\_ neck, spine injury | \_\_\_\_ fusions |
| \_\_\_\_ neck pain | \_\_\_\_ skin rashes | \_\_\_\_ disk problems |
| \_\_\_\_ mid back pain | \_\_\_\_ low back pain | \_\_\_\_ joint pain |
| \_\_\_\_ wear contacts / dentures | \_\_\_\_ easily bruised | \_\_\_\_ joint swelling |
| \_\_\_\_ sensitivity to pressure | \_\_\_\_ HIV / AIDS | \_\_\_\_ surgery, describe |
| \_\_\_\_ heart attack | \_\_\_\_ osteoporosis | \_\_\_\_ tuberculosis |
| \_\_\_\_ hepatitis  | \_\_\_\_ numbness | \_\_\_\_ sprains |
| \_\_\_\_ TMJ |  |  |

 \_\_\_\_ other, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the massage/bodywork I receive is provided for the relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that the massage, or bodywork, should not be constructed as a substitute for examination, diagnosis or treatment and I should see a physician, chiropractor, or qualified medical specialist for any physical or mental ailment that I am aware of. I understand that massage, or bodywork, practitioners are not qualified to perform spinal skeletal adjustment, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the session given should be construed as such. Because massage, or body work, 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I fail to do so. I also understand that any inappropriate, unprofessional behavior, illicit, or sexually suggestive remarks or sexual misconduct made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Signature Date

Consent for treatment of a minor. By my signature below, I authorize the practitioner to administer massage, or body work, to my child or dependent. (Under 18 years old).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian Date