Lunas Masahe
CLIENT CONSULTATION FORM

Name _____ Phone _____

Address_____

Occupation _____ Email _____

Primary Physician _____ Phone_____

Emergency Contact _____ Phone_____

How did you hear about us? _____

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

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

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your stress level right now? ☐ Low ☐ Average ☐ Somewhat Stressed ☐ Very Stressed

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Do you have any difflculty lying on your front, back, or side? ☐ Yes ☐ No

If yes, please explain_____

List current medications & the conditions they are treating:

_____

_____

Please tell us about any allergies or hypersensitivities

_____

_____

Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain_____

Do you have sensitive skin? ☐ Yes ☐ No

What do you consider your skin type? ☐ Normal ☐ Oily ☐ Acne ☐ Dry ☐ Aging
☐ Combination ☐ Sensitive ☐ Rosacea ☐ Other

Do you sit for long hours at a workstation, computer, or driving ☐ Yes ☐ No

If yes, please explain_____

Do you perform·any repetitive movement in your work, sports,or hobby? ☐ Yes ☐ No

If yes, please explain_____

List any major accidents or surgeries

_____

_____

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MEDICAL HISTORY FORM

GENERAL STATE OF HEALTH

Do you smoke? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO

Do you exercise regularly? ☐ YES ☐ NO

Are you taking any medication? ☐ YES ☐ NO

Are you on any special diet? YES NO

FEMALES ONLY

Could you be pregnant? ☐ YES ☐ NO Haveyou had an IUD fitted in the last 12 weeks? ☐ YES ☐ NO

PLEASE MARK ALL THAT APPLY TO YOU

- ☐ Headaches / migraines
- ☐ Vertigo / dizziness
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Asthma Shortness of breath
- ☐ Sensory loss / change
- ☐ Numbness / tingling
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tendonitis
- ☐ Pins / plates / wires / artificial joint
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart disease
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Lyme disease
- ☐ Infectious skin conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive conditions
- ☐ Chronic fatigue syndrome
- ☐ Depression Anxiety
- ☐ Pregnant
- ☐ Given birth
- ☐ Gynecological problems
- ☐ Other conditions

_____

_____

Please indicate current problem areas in your body by marking letters from the key on the diagrams

INTENSITY OF PAIN:

1 2 3 4 5 6 7 8 9 10

PRIMARY AREA OF PAIN:

☐ Adhesion ☐ Spasm ☐ Rotation ☐ Inflammation

☐ Pain ☐ Trigger point ☐ Tender Point ☐ Elevation

TIME PATTERN OF PAIN

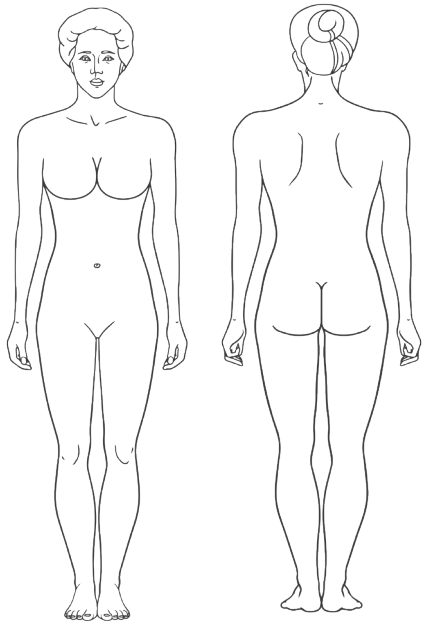
- ☐ Constant (pain does not change)
- ☐ Intermittent (intensity doesn't change but comes & goes)
- ☐ Variable (intensity changes throughout the day)

Pain/discomfort is brought on or made worse by

_____

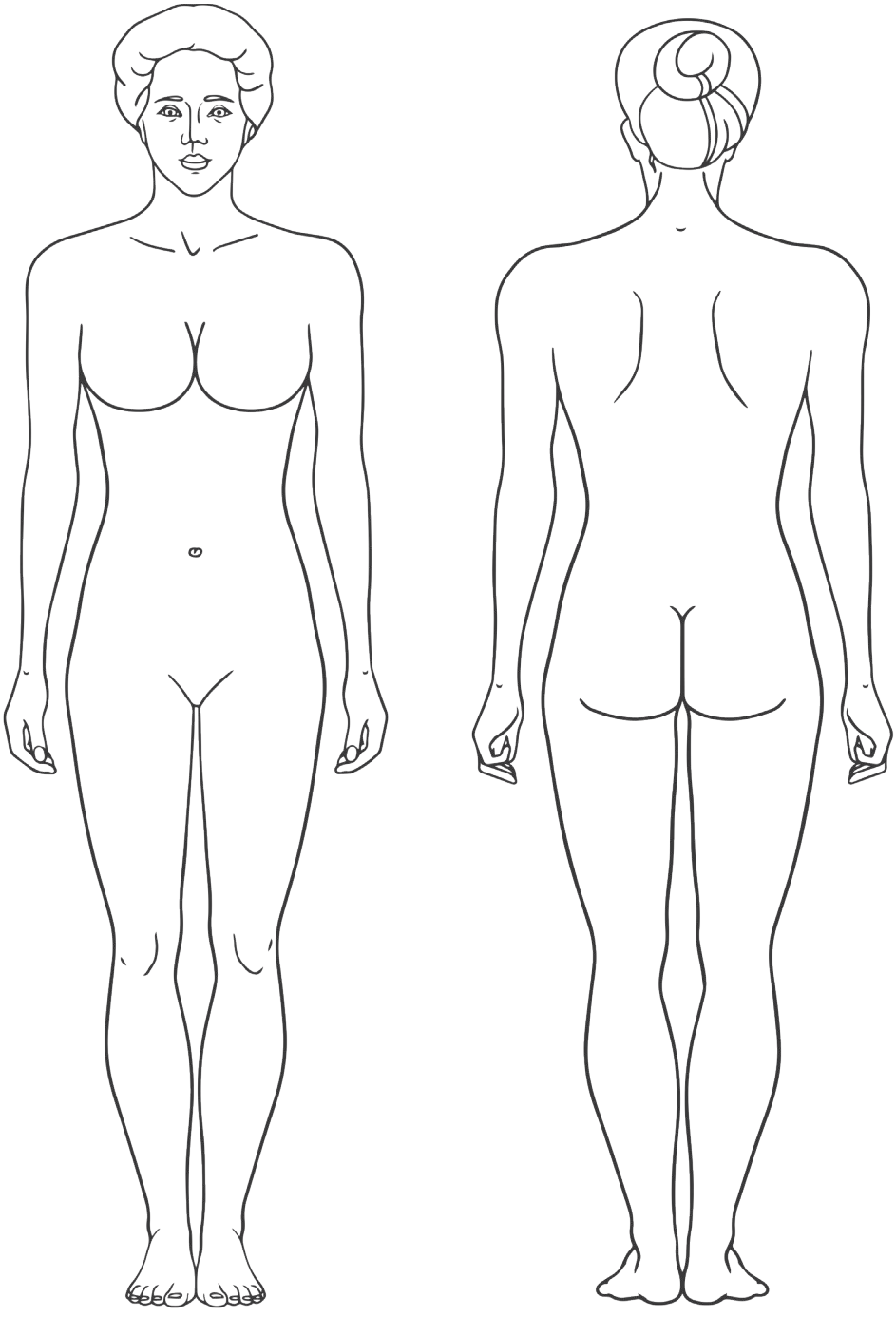
Pain/discomfort feels better with

_____



BODY ANALYSIS

THERAPIST NOTES



UPPER BODY

LOWER BODY

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LIABILITY RELEASE FORM

☐ I give my permission to receive massage services.

☐ I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis.

☐ I understand that the service provider does not diagnose illnesses or injuries, or prescribe medications.

☐ I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I have clearance from my physician to receive massage therapy.

☐ I understand the risks associated with massage therapy include, but are not limited to: superficial bruising or redness, short-term muscle soreness, exacerbation of undiscovered injury.

☐ I, therefore, release the service provider from all liability concerning these injuries that may occur during the massage session.

☐ I understand the importance of informing the service provider of all medical conditions and medications I am taking, and to let the service provider know about any changes to these. I understand that there may be additional risks based on my physical condition.

☐ I understand that it is my responsibility to inform the service provider of any discomfort I may feel during the session so she may adjust accordingly.

☐ I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

☐ I understand that I or the service provider may terminate the session at any time.

☐ I have been given a chance to ask questions about the sessionand my questions have been answered.

CLIENT SIGNATURE (ADULT)_____

PARENT/GUARDIAN CONSENT (UNDER 18 YRS OF AGE):

I, _____, authorize my specialist to perform the service on _____ (A MINOR).

PARENT / GUARDIAN SIGNATURE_____

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TREATMENT PLAN

DATE	REASON FOR TREATMENT	TREATMENT AIM	MEDIUM	THERAPIST
TREATMENT PLAN				
NOTES				

DATE	REASON FOR TREATMENT	TREATMENT AIM	MEDIUM	THERAPIST
TREATMENT PLAN				
NOTES				

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DATE	REASON FOR TREATMENT	TREATMENT AIM	MEDIUM	THERAPIST
TREATMENT PLAN				
NOTES				

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SOAP NOTES

Client Name _____ Date _____

SUBJECTIVE

Client Goals _____

Symptoms _____

_____

Improve with _____ Worsen with _____

OBJECTIVE

Visual _____

_____

Palpation _____

_____

Modalities Applied _____

_____

ASSESSMENT

Changes Achieved _____

_____

Goals _____

PLAN

Treatment Plan _____

_____

At Home Care Plan _____

_____

PRENATAL MASSAGE
CONSULTATION AND CONSENT FORM

Name _____ Phone _____

Address_____

General information about your pregnancy/health history is helpful in planning a massage session that is safe and effective.

What week/month are you in this pregnancy?_____ What is your due date? _____

Who is your prenatal healthcare Povider?_____

What number pregnancy is this for you?_____ How many children do you already have?_____

Are you currently taking any medications? Yes ✔ No

If yes, please list. _____

Please check any health condition listed below (or add) that applies to you in your past or present:

- ☐ History of miscarriage
- ☐ Gestational Diabetes
- ☐ Cardiac, pulmonary, liver, or renal disorders
- ☐ Mother's age under 20 or over 35
- ☐ Pitting edema
- ☐ Epilepsy or other convulsive disorders
- ☐ Placental or cervical dysfunction
- ☐ Abdominal pain
- ☐ Leaking of amniotic fluid
- ☐ Fever
- ☐ Sudden edema/swelling
- ☐ Severe headaches
- ☐ Preeclampsia
- ☐ History of any high-risk pregnancy
- ☐ Drug exposure
- ☐ Multiples
- ☐ Hypertension
- ☐ Genetic abnormalities
- ☐ Fetal growth retardation
- ☐ Bloody discharge
- ☐ Sudden weight gain
- ☐ Diarrhea
- ☐ Decrease in fetal movement over 24-hour period
- ☐ Severe nausea or vomiting

☐ I,_____, 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 service provider or 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.

CLIENT SIGNATURE (ADULT)_____

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RESPONSE CARDS

DATE
TECHNIQUES APPLIED

DURATION

FUTURE TREATMENT

RECOMMENDATIONS

RESPONSE FROM CLIENT

DATE
TECHNIQUES APPLIED

DURATION

FUTURE TREATMENT

RECOMMENDATIONS

RESPONSE FROM CLIENT