

# Friendswood Massage and Acupuncture Clinic

## Massage Therapy Consultation and Release Form

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

Address: \_\_\_\_\_ Cell: # \_\_\_\_\_

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Birthday \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: # \_\_\_\_\_

How did you learn about us? Web \_\_\_ Phone Book \_\_\_ Newspaper \_\_\_ Friends/Family \_\_\_

Who referred you? \_\_\_\_\_

The indications for massage are stress, muscle pain, soreness and spasms, pain in the joints, hands and feet, and headaches.

Body parts to be massaged may include the face neck, shoulders, back, arms, buttocks, hip flexors, legs, pectorals, abdominals, ribs and feet.

Standard draping will be used at all times during the massage, meaning only the body part being massaged will be exposed. ***The Therapist may massage the chest muscle, but will not massage the breast.***

I understand if I am uncomfortable for any reason I may terminate/cease the massage session and the therapist is required to end the session. Client's initials \_\_\_\_\_

If you have any questions, please let us know and we will answer to the best of our knowledge. ***If you experience pain during the massage session, please let the massage therapist know so He or She can adjust the technique.*** Communication between therapist and client is very important.

I, \_\_\_\_\_ understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation, and is not of a sexual nature. You massage therapist may terminate the service without a refund, if inappropriate language or actions occur. I understand the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and /or diagnosis and that it is recommended that I see a physician for any physical conditions. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. If I am under 18 years of age, a parent or parental guardian must also sign for approval of my getting massaged.

Name (signature) \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian (signature) \_\_\_\_\_ Date \_\_\_\_\_

Client's Name: \_\_\_\_\_

Have you received Massage Therapy? \_\_\_\_\_ What kinds? \_\_\_\_\_ How often? \_\_\_\_\_

Please check off any of the following conditions or symptoms which apply to you now or in the past.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Muscle Sprain / Strain |
| <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Heart Problems         |
| <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Allergy to Nut Oils | <input type="checkbox"/> Bursitis              | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Skin Problems         | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hypo or Hyperglycemia | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> Other Conditions       |

Please List and explain other conditions/symptoms you are or have experienced: \_\_\_\_\_

Have you had any serious or chronic illness, operations, or traumatic accidents? If yes, please explain:

\_\_\_\_\_

Are you currently, or have you at any time within the last 12 months been under the care of a Physician? \_\_\_\_\_ If so, for what condition? \_\_\_\_\_

Are you taking blood thinner? \_\_\_\_\_ If yes, which ones? \_\_\_\_\_ For how long? \_\_\_\_\_

Are you on any medication? \_\_\_\_\_ If yes, which ones? \_\_\_\_\_

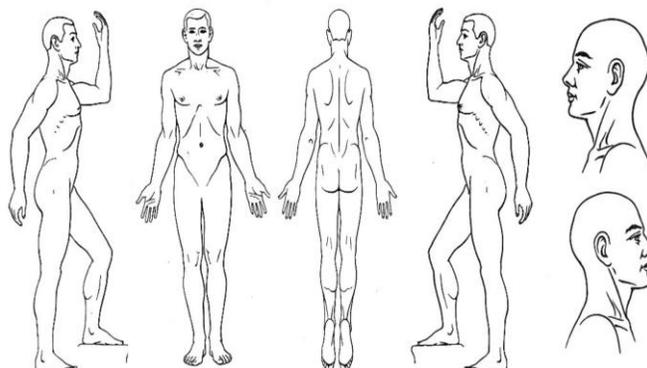
Do you wear contacts? \_\_\_\_\_ Do you wear dentures? \_\_\_\_\_

Do you participate in sports? \_\_\_\_\_ Which ones? \_\_\_\_\_

Techniques to be used may include:

- Swedish
- Deep Tissue
- Trigger Point
- Reflexology
- Hot Stone Massage

### PLEASE CIRCLE AREAS OF COMPLAINT



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## Prenatal Massage Form

The following questions will assist me in being aware of any individual health concerns for both you and your baby during pregnancy as well as during the postpartum months after labor. Please notify me of any changes that seem concerning so I can adjust your sessions accordingly. This will insure for safe, relaxing and supportive sessions each and every time.

If a question does not pertain to you at this time, then please write NA for your answer rather than leaving it blank.

Today's Date: \_\_\_\_\_ Client Name: \_\_\_\_\_

Name of physician/ midwife and phone number: \_\_\_\_\_

In your primary care physician aware you are receiving a massage or do you have a doctor's note? Yes No

# of weeks into pregnancy? \_\_\_\_\_ Due Date: \_\_\_\_\_

Is this your first pregnancy? Yes No If no, how many other pregnancies including this one? \_\_\_\_\_

What delivery method did you use with your previous child? Vaginal C-Section

Did you use an epidural? Yes No Is this your first prenatal massage? Yes No

Birth support team: mark H if used before, mark P if using this pregnancy and mark U if undecided:

Hospital \_\_\_\_\_ Birthing Center \_\_\_\_\_ Home Birth \_\_\_\_\_

Pregnancy Difficulties mark H for History and P for Present:

High-risk \_\_\_\_\_ Bed rest \_\_\_\_\_ Premature birth \_\_\_\_\_ Miscarriage \_\_\_\_\_ Heavy discharge \_\_\_\_\_ Diabetes \_\_\_\_\_

Contagious illness \_\_\_\_\_ Fever \_\_\_\_\_ Vomiting \_\_\_\_\_ Unusual pain \_\_\_\_\_ Preeclampsia \_\_\_\_\_

High blood pressure \_\_\_\_\_ Morning sickness \_\_\_\_\_ Abdominal pain \_\_\_\_\_ Diarrhea \_\_\_\_\_

What areas of the body would you like the therapist to focus on today?

Neck \_\_\_\_\_ Arms \_\_\_\_\_ Pecs \_\_\_\_\_ Legs \_\_\_\_\_ Abdomen \_\_\_\_\_ Head \_\_\_\_\_ Scalp \_\_\_\_\_ Back \_\_\_\_\_

### **Pregnancy Massage Information and Informed Consent**

Massage during pregnancy provides many benefits. It enhances circulation, supporting the work of your heart, and increasing the oxygen and nutrients delivered to your baby. It can relieve the sensation of heaviness and aching in your legs caused by swelling or varicose veins. It can optimize your muscle tone and function, relieve muscle strain and fatigue, and reduce strain on your joints. Pregnancy massage reduces stress promotes relaxation, contributing to a healthier pregnancy. If you have been told that your pregnancy is high risk, please notify the therapist.

Please read and sign the acknowledgment below:

I have received and read written information concerning the possible benefits of massage therapy during pregnancy. I verify that I am experiencing a low risk pregnancy, and I have stated all my known medical conditions. I understand that I will be receiving massage therapy for the purpose of stress reduction, relief from muscle tension or spasm, or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, and, as such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does she perform spinal manipulations. I am aware that this massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a physician for any ailment I might have. I understand and agree that I am receiving massage therapy entirely at my own risk. In this event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I HEREBY HOLD HARMLESS AND INDEMNIFY the therapist, her principals, and agents from all claims and liability whatsoever.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_