Massage Intake Form--CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name:		Date of Birth:	
Address:		Email:	
City:	State: ZIP:	Home Phone:	
Occupation:	Who Referred You:	Work Phone:	

Have you ever received massage therapy? _____Yes _____No

Type of massage experienced (Swedish, Neuromuscular, Deep Tissue, etc.)_____

Are you currently taking medications? _____Yes _____No

If yes, please list name and reason for medications.

_____

_____

Are you currently seeing a healthcare professional? _____Yes _____No

If yes, please list names and reasons/treatment.

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

____	arthritis	____	depression, panic disorder, other psych conditions	____	hepatitis (A,B,C, other)
____	diabetes	____	diverticulitis	____	skin condition
____	blood clots	____	headaches	____	stroke
____	broken/dislocated bones	____	heart conditions	____	surgery
____	bruise easily	____	back problems	____	TMJ disorder
____	cancer	____	high blood pressure	____	Seizures
____	chronic pain	____	Insomnia	____	Scoliosis
____	constipation/diarrhea	____	muscle strain/sprain	____	
____	Whiplash	____	Chemical Dependency	____	

*AIDS, fibromyalgia, chronic fatigue, lupus, etc.

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____

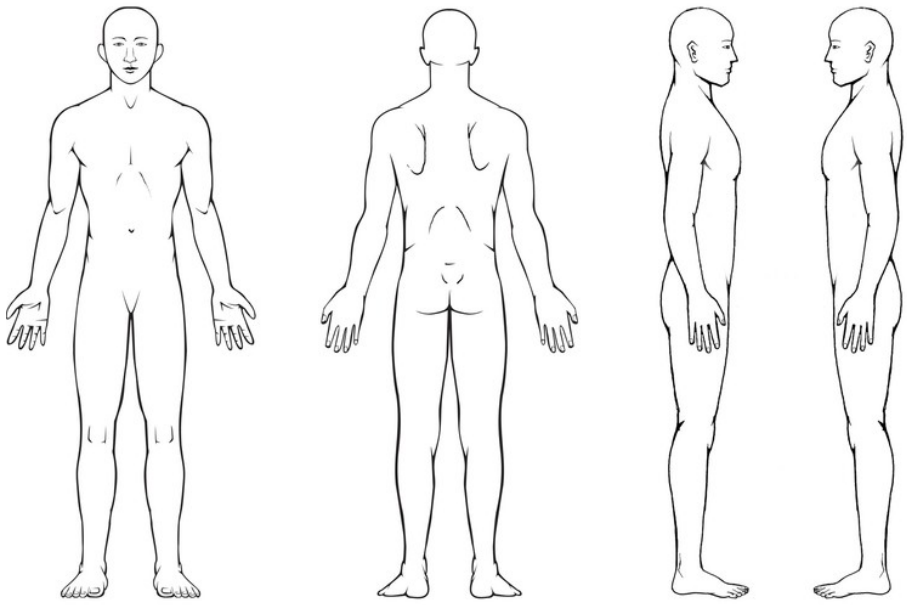
Signature: Date:

Do you have any of the following today:
____skin rash ____cold/flu _____ open cuts ____severe pain _____ anything contagious _____ injuries/ bruises

Do you have any allergies to:
____medications _____ foods (nuts, etc.)
_____ environmental allergens (dust,pollen, fragrances) _____ reactions to skin care products

If any of the above are checked, please give details:_____
_____
_____

Are you wearing: _____ contact lenses _____ hearing aid _____ hairpiece



Thank you for taking the time to complete this form. My goal is to do all I can to help you achieve the level of health and wellness you would love to have.

Please mark your scars/tattoos above, along with pain areas.

What are your goals/expectations for this therapy session?_____
_____
_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position—sighing, yawning, change in breathing, stomach gurgling—emotional feelings and/or expression—movement of intestinal gas—falling asleep—memories

Signature: Date:

State law requires that consent must be provided for the following areas to ensure the safety of the client and practitioner.

Please Initial.

_____ **Torso (males only):** I consent to having my torso/chest uncovered at times during the massage.

_____ **Assistance with dressing/undressing:** I require assistance with undressing and dressing, which may expose my breasts and gluteal cleft area.

_____ **Gluteal area:** I consent to having my glute/hip rotators touched as part of a therapeutic protocol. Understanding that, as a rule, I will be covered and at times only the area being worked on will be exposed, depending on the treatment.

_____ I understand **I have the right to rescind my consent and refuse any of the above treatments at any time, even in the middle of a treatment session.** The consent is valid until I inform my therapist that I want to change it.

Please ***initial*** if you approve the use of the following modalities, should they ever be offered to you and okayed verbally during your session;

_____ Cupping
____ Gua Sha/IASTM
____ Aromatherapy/Essential Oils
____ Hot Stone

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

If you sign a consent form, we may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice. Examples are quality assessment and improvement activities, audits, cost-management analysis, and customer service reviews.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

Any other useless and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except tot the extent that we have already take actions relying on your authorization.

You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it until you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information form us by alternative means or at her native locations.
- The right to inspect and copy your protected health information.

I, _____(print name) have received a printed comply and understand my rights relating to the privacy practices guaranteed by the Health Insurance Portability & Accountability Act of1996 ("HIPAA").

Signature: Date:

Stewart Health

Vancouver, WA 98661
360-281-5168

CANCELLATION POLICY

We are pleased that you have chosen us to become part of your health care team by providing Therapeutic Massage Therapy. We are sure that you understand that when we reserve this amount of time specifically for your therapy session that difficulties occur when you are unable to keep your reservation. Reluctantly out of necessity, there is a cancellation policy for your massage appointments. It is as follows:

1. **Except in the case of illness or emergency, you will be financially responsible for payments of missed appointments if not cancelled at least *twenty four(24)* hours in advance. Missed or cancelled appointments without *twenty four(24)* hours notice will be charged *$60* for the missed session.**
2. **If you are late for an appointment, treatment time will be extended if possible. If time can not be extended you will still be charged for a full session.**

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

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during this 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 massage therapy should not be construed as a substitute for medical examination, diagnosis of 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 practitioner's are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. Because therapy is contraindicated 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 forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment.

Signature: Date:

Additional Intake form – COVID-19

Due to the infectious nature of COVID-19, this additional intake form must be completed before each massage therapy session. Please know that people with COVID-19 can be asymptomatic and still be contagious. There is no way to completely protect ourselves from this virus. Ask for the checklist of precautions to see how I am disinfecting my office between sessions. And please answer these questions truthfully and do everything asked so we can do our best to protect each other. Thank you!

Testing status:

1. Have you been tested for COVID? Yes / No
The antibody? Yes / No
2. When? _____
What were the results? _____

Symptoms:

3. Are you experiencing
Fever? Yes / No
Temperature reading: _____
Cough? Yes / No
Sore throat? Yes / No
Shortness of breath? Yes / No
Oximeter reading: _____
Sudden loss of taste and smell? Yes / No
Fatigue? Yes / No
Chills? Yes / No
Nasal or sinus congestion? Yes / No
Sudden onset body aches? Yes / No
New rash or other changes to your skin? Yes / No
Have you been doing regular cardio exercise? Yes / No

Exposure:

4. Are you aware of having been exposed to someone with COVID-19 or anyone who has been exposed to someone with COVID-19? Yes / No
5. Have you done any air travel, domestic or international recently? Yes / No
6. Have you traveled to any places with a high infection rate, where people have not been isolating (no stay at home order), or been in any groups of people where social distancing was not observed? Yes / No

Precautions:

7. What precautions have you taken to limit your exposure to the virus?

_____

_____

8. Do you spend time around anyone considered high risk, such as elderly with co-morbidities or immunocompromised family members? Yes / No

Requested Actions:

9. Are you willing to wash or sanitize your hands upon entering my office and post-massage? Yes / No
10. Are you willing to wear a face mask at all times in my office and during the session? Yes / No

Signature: Date: