MASSAGE INFORMED CONSENT FORM
LICENSED MASSAGE THERAPIST: Shamani Langille

FIRST:_____ MIDDLE:_____ LAST:_____

BIRTHDATE:_____/_____/_____ AGE:_____ _____ FEMALE _____ MALE

STREET:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____

EMERGENCY CONTACT:_____ PHONE:_____

HEIGHT:_____FT._____IN. WEIGHT:_____ LBS.

_____ SINGLE _____ MARRIED: ANNIVERSARY DATE:_____/_____/_____ _____ OTHER

HOW DID YOU HEAR ABOUT US? REFERRED BY?_____

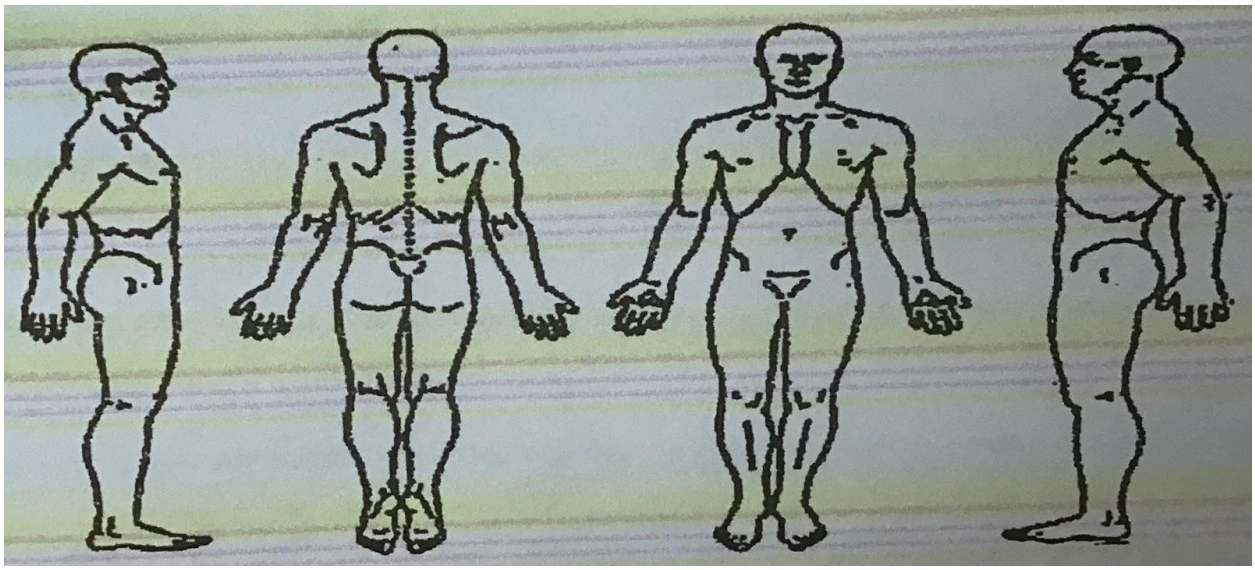
_____ EMPLOYED OCCUPATION:_____

HOBBIES:_____
_____ FULL TIME STUDENT _____ PART TIME STUDENT
___SMOKE EVERY DAY ___SMOKE SOME DAYS ___FORMER SMOKER ___NEVER SMOKED
HOW WOULD YOU RATE YOUR OVERALL HEALTH?
___EXCELLENT ___VERY GOOD ___GOOD ___FAIR ___POOR
HAVE YOU HAD PREVIOUS MASSAGE? ___YES ___NO
IF YES, WHAT WERE YOUR RESULTS: ___EXCELLENT ___GOOD ___FAIR ___POOR

WHAT IS YOUR GOAL/CONCERN FOR TODAY'S SESSION?_____

_____
WHAT KIND OF PRESSURE DO YOU PREFER? ___LIGHT ___MEDIUM ___FIRM
ARE YOU SENSITIVE TO TOUCH OR PRESSURE IN ANY AREA? ___YES PLEASE ___NO
IF YES, PLEASE EXPLAIN:_____
DO YOU EXPERIENCE ANY DIFFICULTY LYING EITHER ON YOUR FRONT OR YOUR BACK? ___YES FRONT ___YES BACK
IS THERE ANY AREA WHERE YOU WOULD LIKE EXTRA TIME SPENT, ANY AREA WHERE YOU SEEM TO HOLD A LOT OF TENSION?_____
HAVE YOU EVER BEEN HOSPITALIZED? ___NO ___YES
IF YES, WHY AND WHEN:_____
LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND WHEN THEY OCCURED:
_____
_____
HAVE YOU HAD SIGNIFICANT PAST TRAUMA (FRACTURES, FALLS, AUTO ACCIDENTS, ETC.)?
___NO ___YES IF YES, EXPLAIN:_____
ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITIONS? ___NO ___YES
IF YES, FOR WHAT CONDITION?_____
NAME AND FACILITY OF PHYSICIAN:_____
ARE YOU CURRENTLY TAKING ANY MEDICATION? ___NO ___YES
IF YES, EXPLAIN:_____
DO YOU HAVE NUMBNESS OR STABBING PAINS? ___NO ___YES
IF YES, EXPLAIN:_____
DO YOU CURRENTLY HAVE CANCER? ___NO ___YES EXPLAIN:_____
DO YOU HAVE LYMPH NODES REMOVED? ___NO ___YES EXPLAIN:_____

INDICATE ON THE DRAWINGS BELOW WHERE YOU HAVE PAIN/SYMPTOMS.



LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION: (IF TOO NUMEROUS, ATTACH A COPY OF YOUR MEDICATIONS.)

_____

_____

LIST ALL THE OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, AND/OR HERBS YOU ARE CURRENTLY TAKING AND WHY:

_____

_____

WHAT ARE YOUR MASSAGE GOALS?

_____

_____

HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN?
____YES ____NO IF YES, PLEASE LIST:

_____

_____

WHAT CHALLENGES DO YOU HAVE OR WANT TO OVERCOME?

_____

_____

HERE IS A LIST OF THINGS MASSAGE CAN HELP WITH. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:

REDUCE STRESS AND ANXIETY REDUCE MUSCLE SORENESS AND TENSION
IMPROVE CIRCULATION IMPROVE IMMUNE FUNCTION IMPROVE MOOD
REDUCE PAIN SLEEP BETTER IMPROVE FLEXIBILITY AND RANGE OF MOTION
LOWER HEART RATE AND BLOOD PRESSURE INCREASE RELAXATION

ARE THERE CERTAIN STANDING OR SITTING POSITIONS YOU NEED TO AVOID OR THAT ARE PAINFUL OR UNCOMFORTABLE? ____YES ____NO
IF YES, PLEASE LIST AND EXPLAIN:

_____

_____

IF YOU HAVE PAIN(S), HOW OFTEN DO YOU EXPERIENCE YOUR PAIN SYMPTOMS?
___CONSTANTLY (76-100% OF THE TIME) ___FREQUENTLY (51-75% OF THE TIME)
___OCCASIONALLY (26-50% OF THE TIME) ___INTERMITTENTLY (1-25% OF THE TIME)

HOW WOULD YOU DESCRIBE THE TYPE OF PAIN?
___SHOOTING ___NUMB ___DULL ___TINGLY
___SHARP WITH MOTION ___ACHY ___STIFF ___DIFFUSE
___STABBIN WITH MOTION ___SHARP ___BURNING ___STIFF
___SHOOTING WITH MOTION ___ELECTRIC LIKE WITH MOTION
___OTHER:_____

HOW ARE YOUR SYMPTOMS CHANGING WITH TIME?
___GETTING WORSE ___STAYING THE SAME ___GETTING BETTER

USING A SALE FROM 1-10 (10 BEING THE WORST), HOW WOULD YOU RATE YOUR PROBLEM? (PLEASE CIRCLE.)
0 1 2 3 4 5 6 7 8 9 10

HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR WORK?
__NOT AT ALL ___A LITTLE BIT ___MODERATELY ___QUITE A BIT __EXTREMELY

HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR SOCIAL ACTIVITIES?
__NOT AT ALL ___A LITTLE BIT ___MODERATELY ___QUITE A BIT __EXTREMELY

WHO ELSE HAVE YOU SEEN FOR YOUR PROBLEM?
___CHIROPRACTOR ___NEUROLOGIST ___PRIMARY CARE PHYSICIAN
___ER PHYSICIAN ___ORTHOPEDIST ___MASSAGE THERAPIST ___NO ONE
___PHYSICAL THERAPIST ___YOGA TEACHER ___OTHER:_____

RECENT: ___X-RAYS ___MRI ___CT ___LAB WORK TAKEN:_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

HOW DO YOU THINK YOUR PROBLEM BEGAN?_____

DO YOU CONSIDER THIS PROBLEM TO BE SEVERE? __YES __YES, AT TIMES __NO

WHAT AGGRAVATES YOUR PROBLEM?_____

WHAT HELPS YOUR PROBLEM?_____

WHAT CONCERNS YOU THE MOST ABOUT YOUR PROBLEM; WHAT DOES IT PREVENT YOU FROM DOING?_____

_____

FOR EACH OF THE CONDITIONS LISTED BELOW, PLACE A CHECK IN THE “PAST” COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST. IF YOU PRESENTLY HAVE A CONDITION LISTED BELOW, PLACE A CHECK IN THE “NOW” COLUMN.

	YES PAST	NOW	NO		YES PAST	NOW	NO
Pregnancy	___	___	___	Anemia	___	___	___
Headaches	___	___	___	Raynaud’s	___	___	___
Neck Pain	___	___	___	Easy Bruising	___	___	___
Whiplash	___	___	___	Angina	___	___	___
Upper Back Pain	___	___	___	Kidney Stones	___	___	___
Mid Back Pain	___	___	___	Kidney Disorders	___	___	___
Low Back Pain	___	___	___	Bladder Infection	___	___	___
Herniated Disc	___	___	___	Painful Urination	___	___	___
Shoulder Pain	___	___	___	Loss of Bladder	___	___	___
Elbow/Upper Arm Pain	___	___	___	Frequent Urination	___	___	___
Wrist Pain	___	___	___	Abdominal Pain	___	___	___
Hand Pain	___	___	___	Irritable Bowel Syndrome	___	___	___
Hip Pain	___	___	___	Abdnormal Weight Gain	___	___	___
Upper Leg pain	___	___	___	Abdnormal Weight Loss	___	___	___
Knee Pain	___	___	___	Loss of Appetite	___	___	___
Ankle/Foot Pain	___	___	___	Crohn’s	___	___	___
Jaw Pain	___	___	___	Hernia	___	___	___
Whiplash	___	___	___	Ulcer	___	___	___
Joint Pain/Stiffness	___	___	___	Hepatitis	___	___	___
Arthritis	___	___	___	Liver/Gall Bladder Disorder	___	___	___
ALS	___	___	___	General Fatigue	___	___	___
Parkinson’s	___	___	___	High Stress/Anxiety	___	___	___
Multiple Sclerosis	___	___	___	Panic Attacks	___	___	___
Neuritis/Neuralgia	___	___	___	Fibromyalgia	___	___	___
Fibrositis	___	___	___	Hypothyroidism	___	___	___
Rheumatoid Arthritis	___	___	___	Hyperthyroidism	___	___	___
Cancer	___	___	___	Endocrine Disorders	___	___	___
Auto Immune Disease	___	___	___	Muscular Incoordination	___	___	___
Osteoporosis	___	___	___	Visual Disturbances	___	___	___
Orthopedic Pins/Plates	___	___	___	Dizziness	___	___	___
Tumor, Cysts, Lipomas	___	___	___	Diabetes	___	___	___
Asthma/Breathing Problems	___	___	___	Excessive Thirst	___	___	___
Pneumonia	___	___	___	Poor Sleep / Insomnia	___	___	___
Chronic Sinusitis	___	___	___	Tinnitis, Ear Ringing	___	___	___
Heart Problems	___	___	___	Prostte Problems	___	___	___
High Blood Pressure	___	___	___	Smoking / Tobacco Use	___	___	___
Low Blood Pressure	___	___	___	Drug / Alcohol Dependence	___	___	___
Heart Attack	___	___	___	Allergies	___	___	___
Chest Pains	___	___	___	Depression	___	___	___
Stroke	___	___	___	Grieving	___	___	___
Peripheral Artery Disease	___	___	___	Systemic Lupus	___	___	___
Blood Clots, Phleboliths	___	___	___	Epilepsy	___	___	___
Hemophilia	___	___	___	Dermatitis/Eczema/Rash	___	___	___
Varicose/Spider Veins	___	___	___	HIV/AIDS	___	___	___
Bad Circulation	___	___	___	Rash	___	___	___
Gout	___	___	___	Osteoarthritis	___	___	___
Pregnant	___	___	___	Other Conditions:	___	___	___

PLEASE READ AND INITIAL BEFORE EACH STATEMENT.

_____I UNDERSTAND THAT MASSAGE THERAPY GIVEN HERE IS FOR THE PURPOSE OF STRESS REDUCTION, RELIEF FROM MUSCLE TENSION OR SPASM, OR FOR INCREASING CIRCULATION AND ENERGY FLOW. IF AT ANY TIME I FEEL DISCOMFORT, I WILL INFORM MY MASSAGE THERAPIST.

____I UNDERSTAND THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MASSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMACEUTICALS, NOR DO THEY PERFORM ANY SPINAL MANIPULATIONS. IT HAS BEEN MADE VERY CLEAR TO ME THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS AND/OR DIAGNOSIS AND THAT IT IS RECOMMENDED THAT I SEE A PHYSICIAN FOR ANY AILMENTS THAT I HAVE.

____I UNDERSTAND AND AGREE THAT I AM RECEIVING MASSAGE THERAPY ENTIRELY AT MY OWN RISK. IN THE EVENT THAT I BEOME INJURED EITHER DIRECTLY OR INDIRECTLY AS A RESULT, IN HOLE OR IN PART, OF THE AFORESAID MASSAGE THERAPY, I HEREBY HOLD HARMLESS AND INDEMNIFY ABC YOGA CLUB, OWNERS, DIRECTORS, THERAPISTS, AND AGENTS FROM ALL CLAIMS AND LIABILITY WHATSOEVER.

___I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND WILL KEEP THE MASSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

___THE MASSAGE GIVEN HERE IS THERAPEUTIC. ANY ATTEMPT TO SEXUALIZE THE RELATIONSHIP WILL NOT BE TOLERATED, AND IS GROUNDS FOR TERMINATION OF THE MASSAGE AND I WILL BE LIABLE FOR PAYMENT OF THE SCHEDULED APPOINTMENT.

___CANCELLATIONS AND RESCHEDULES MUST BE MADE NO LES THAN 24 HOURS. A MISSED APPOINTMENT OR CANCELLATION WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED $60.00. IF LATE, THE SESSION WILL END AT THE APPOINTED TIME. PAYMENT IS DUE ON THE DATE OF SERVICE.

_____ _____

CLIENT SIGNATURE. DATE

CONSENT TO TREATMENT OF MINOR: BY MY SIGNATURE BELOW, I HEREBY AUTHORIZE MASSAGE AND BODYWORK TECHNIQUES TO MY CHILD OR DEPENDENT AS THEY DEEM NECESSARY.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE