Holistic Health Clinic 4670 SW Washington Ave. Beaverton, OR 97005

Confidential Client Health Information for Massage Therapy

Name_____

Address_____ City/State_____ Zip _____

Home Phone_____ Work Phone_____ Cell_____

Email_____ DOB_____ Employer_____ Occupation_____

Emergency Contact # _____ Contact Name & relation _____

Referred By_____ Have you ever had a massage before?_____

Purpose for today's massage_____

List any medications you are taking:_____

Please check if you have any of the following conditions:

___Recent Injury
___Recent Illness
___Chronic Illness
___Cancer
___Phlebitis
__Other_____

___Diabetes
___Kidney Problems
___Recent Surgery
___Pregnancy
___Wear Contact Lenses

___Varicose Veins
___Blood Clots
___Allergies to Scents/Oils
___Skin Condition
___High/Low Blood Pressure

Please explain above_____

Are you currently under a doctor's care for any of the conditions above?_____

Name of Physician _____ Phone #_____

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do not want a copy _____ Received a copy

Signature _____ Date _____

CANCELLATION POLICY

To avoid being charged a $45 cancellation fee, I agree to give 24 hours notice.

Signature: _____ Date: _____

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MASSAGE CONSENT FORM

I have been advised of the policies and procedures pertaining to massage and I understand these policies. The massage procedures, information about massage in general, benefits and contraindications of massage, and possible alternative therapies have been explained to me.

I understand that the massage I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis, and I should see a health care provider for those services. Because massage should not be performed under some circumstances, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist and Holistic Health Clinic from any liability if I fail to do so.

_____ _____

Signature of Patient **Date**

Consent to Treat a Minor:

I_____ parent/guardian of _____ have read and understood the statements regarding massage therapy. By my signature, I authorize a Holistic Health Clinic massage therapist to provide massage treatments and bodywork to my child or dependent.

Signature of Custodial Parent or Guardian _____ Date _____