

Kettering Therapeutic Massage Confidential Client Information and Health History

Name:		Date:	
Address:		City:	State: Zip:
Phone #:	Home:	Work:	Cell:
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Emergency Contact:			Phone:
Referred By:		Do you have a prescription for medical massage?	
Occupation:		Is this your first professional massage?	
Are you currently under the care of a physician? Name: _____ Phone: _____			
Are you currently under the care of a Chiropractor or Physical Therapist? Explain: _____ _____			
Current Medications:	Taking for:	Allergies: _____ _____ _____	
_____	_____	Are you allergic to any scents or essential oils? _____ _____	
_____	_____		
_____	_____		
_____	_____		
Injuries or Accidents within the past 5 years: _____ _____ _____ _____		Surgeries within the past 5 years: _____ _____ _____ _____	

CONSENT FOR CARE

- I understand that my Licensed Massage Therapist is not a licensed MEDICAL healthcare provider and that massage/bodywork is not a substitute for medical care, medical examination, or diagnosis. I have stated all my known medical conditions and will inform my therapist of any change in my health status.
- I understand that there is no implied or stated guarantee of success or effectiveness for massage/bodywork sessions. It is my choice to receive massage/bodywork and I give my consent for massage/bodywork.
- I have read the Clinic Policies and Payment Policies document and agree to abide by them. I understand the different pricing for the different levels of service provided by Kettering Therapeutic Massage.
- I understand that the client – therapist relationship will be held in strict confidence.

Client Name: _____

Client Signature: _____ Date: _____
(Parent/Guardian if under 18 years of age)

Kettering Therapeutic Massage

Confidential Client Information and Health History

Are you currently experiencing any of the following conditions?

Flu or Cold Inflammation Fever Infection Contagious Disease

Please check (√) any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ Dysfunction
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other

RESPIRATORY

- Asthma
- Dizziness
- Pneumonia
- Sinusitis
- Trouble Breathing
- Emphysema
- Other

CIRCULATORY

- Anemia
- Hemophilia
- High Blood Pressure
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other

DIGESTIVE

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other

SKIN

- Athletes Foot
- Fungal Infections – Acne
- Dermatitis/Eczema
- Impetigo
- Open Wound or Sore
- Psoriasis
- Rashes
- Warts/Moles
- Other

NERVOUS SYSTEM

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling
- Other

OTHER

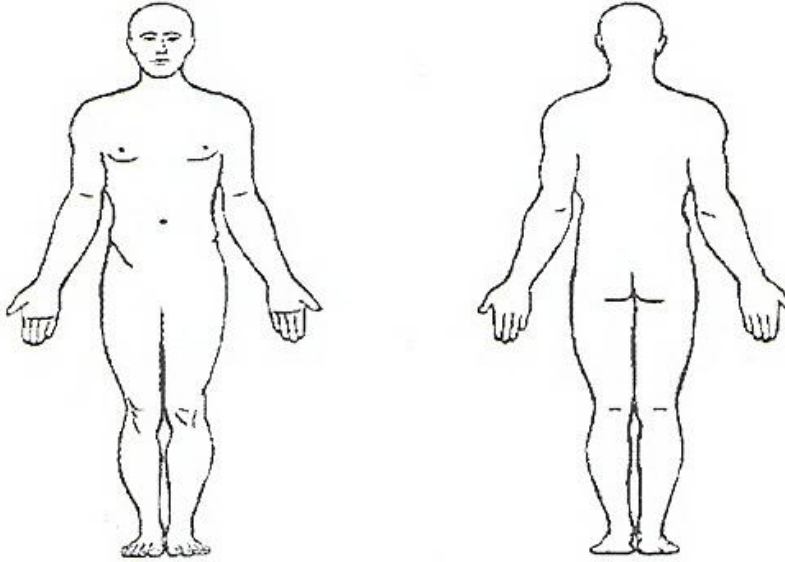
- Cancer
- Sleep Apnea
- Anxiety/Panic Attacks
- PMS
- Physical/Emotional Abuse
- Grief Process
- Insomnia
- Substance Abuse
- Pregnancy
- Chronic Fatigue
- Edema
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- Other

The above information is true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my massage therapist to any physical, mental or emotional changes that occur with my health.

Signature: _____ Date: _____
 (Parent/Guardian if under 18 years of age)

Kettering Therapeutic Massage Confidential Client Treatment and Pain Assessment

Please mark any areas of discomfort:



Do you have any chronic, ongoing pain that you deal with on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____
What activities cause this pain or make it worse? _____ _____ _____
What is your primary goal for your massage/bodywork session? Check all that apply. <input type="checkbox"/> Pain Management <input type="checkbox"/> Reduce Stress <input type="checkbox"/> Relaxation <input type="checkbox"/> Relieve Discomfort <input type="checkbox"/> Maintain Health <input type="checkbox"/> Other: _____
Are you aware of any areas of your body where you seem to hold tension? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what are the locations: _____ _____ _____

The above information is true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my massage therapist to any physical, mental or emotional changes that occur with my health. I fully understand the dangers of obtaining a massage that could result from complications which include, but are not limited to, health problems as stated on the completed medical form. I understand that I may incur complications as a result of my participation in massage therapy at Kettering Therapeutic Massage. I hereby release and forever discharge Kettering Therapeutic Massage, Kimberly Elkins, Robin Albright-Clewell and its employees, officers, and agents from any liability now or in the future arising from my participation in this massage therapy program.

I hereby affirm that I have read and fully understand the above and agree to be legally bound by it. I ALSO AFFIRM I AM OVER 18 YEARS OF AGE.

Signature: _____ Date: _____
(Parent/Guardian if under 18 years of age)

Massage Therapist: _____ Date: _____

Kettering Therapeutic Massage Massage Therapy Informed Consent

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

If you have a medical condition or specific symptoms, massage therapy may be problematic for you. A referral from your primary health care provider may be required prior to treatment being provided; you may wish to contact your primary health care provider to verify that massage is indicated in your situation.

I understand that the treatment I receive is for the basic purpose of relaxation and relief of muscular tension.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, I understand that it is my responsibility to IMMEDIATELY inform the massage therapist, so that the massage can be terminated or the strokes and pressure can be adjusted to a level of comfort.

I further understand that massage therapy is not a substitute for medical examination, diagnosis, and treatment. I understand that the Massage Therapy Scope of Practice, Ohio Revised Code 4731-1-05 does not include any spinal or skeletal adjustment, diagnosis or prescription to treat any physical or mental illness, and that nothing discussed is a replacement for medical advice.

1. Prior to massage, remove all jewelry. Pull long hair back with a clip.
2. Please provide feedback as to pressure (deeper or lighter) and discuss painful or ticklish areas of your body.
3. Feel free to ask questions about the procedures. The massage therapy provider is well trained, ethical, and professional, and will be happy to make you feel well informed and comfortable.
4. Keep all changes to the medical health profile updated; it is especially important to report any changes in health or medications, as massage may be contraindicated in new situations.
5. Any illicit or sexually suggestive remarks or advances will result in immediate termination of the treatment.

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____