Massage Therapy **Client Information**

Client Name:_____

Date of Birth:_____Phone:_____Email:_____

Address:_____

_____

Referred by:_____

Emergency contact:_____Phone:_____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

List the medications you currently take: _____

_____

Have you had any ***injuries, surgeries or diagnoses*** in the past that may influence today's treatment?

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please indicate any conditions that you have or have had in the past. Circle "past" or "current" condition.

Current Past Muscle or joint pain
Current Past Muscle or joint stiffness
Current Past Numbness or tingling
Current Past Swelling
Current Past Bruise easily
Current Past Sensitive to touch/pressure
Current Past High/Low blood pressure
Current Past Stroke, heart attack
Current Past Varicose veins
Current Past Shortness of breath, asthma
Current Past Cancer
Current Past Neurological (e.g. MS, Parkinson's)
Current Past Headaches, Migraines
Current Past Dizziness, ringing in the ears

Current Past Digestive conditions (e.g. Crohn's, IBS)
Current Past Gas, bloating, constipation
Current Past Kidney disease, infection
Current Past Arthritis (rheumatoid, osteoarthritis) Osteoporosis, degenerative spine/disk
Current Past Scoliosis
Current Past Broken bones
Current Past Allergies
Current Past Diabetes
Current Past Endocrine/thyroid conditions
Current Past Depression, anxiety
Current Past Memory Loss, confusion, easily overwhelmed

Jane Hopkins, BA, LMT Jane Cell: 720-934-4106 jane.e.hopkins@gmail.com
Comprehensive PT & Fitness 311 E County Line Rd, #A-5 Littleton, CO 80122 Clinic: 720-542-9712

Consent for Treatment

If I experience pain or discomfort during this session, I will communicate with the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, PT, or other qualified medical specialist for any mental or physical ailment. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed 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 fail to do so. I also understand 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 payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____Date: _____

Parent or Guardian Signature (if minor): _____Date: _____

If you have had a fever in the last 24 hours of 100°F or above or have had any respiratory or flu-like symptoms, sore throat, or cough, please reschedule your appointment. If you have had Covid-19 or flu in the past five days, please reschedule your appointment.

Would you like your practitioner to wear a mask? Yes _____ No_____

Consent for Treatment

I understand that, because massage therapy involves touch and close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

RATES/FEES

Rates payable to *Jane Hopkins*. Cash, checks, Venmo, and Paypal accepted.

1-Hour - $75.00

90 mn - $110.00

Credit cards will incur an additional 3% fee. Thank you for your understanding.

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Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24-hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment.

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time. If you know you will be late, please contact your therapist immediately to see if arrangements can be made to still be seen.

Signature _____ Date _____

I look forward to meeting you!

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