Comfort Zone Massage, LLC

Client Health History and Consent Form

Name _____ Birth Date _____ Today's Date _____

Address _____ City/State Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

BEST METHOD FOR CONFIRMING APPOINTMENTS: Text Cell E-Mail Phone Call Mail None

In case of emergency _____ Telephone _____

Email:_____ Have you had a professional massage? NO YES, When _____

How did you hear about us? _____

Please review this list and circle any illness and/or medical conditions may apply:

Diabetes	Contact lenses	Ruptured/bulging disc.	Nail or skin problems
Heart condition	Elevated cholesterol	Seizures	Skin disorder
High blood pressure	Cancer	Varicose veins	Infectious conditions
Stroke	Arthritis	Autoimmune disorder	Scoliosis
Headache	Previous MVA/trauma	Loss of balance/Vertigo	Fatigue/depression
Pins/needles	Bruxing/griding	Painful joints	Frequent stress
Osteoporosis	Bruise easily	Sensitive to touch	
Numbness/stabbing pain	Contagious disease	Cardiac or circulatory concerns	

Any known allergies (nuts, oils etc…)_____

Medications: ____ Vitamins ____ Herbs ____ Aspirin/Anti-inflammatory ____ Muscle Relaxants

____ Pain Reducers ____ Anti-anxiety/Depressants ___Sleeping Pills ___Steroids

____ Blood thinners (coumadin, plavix, daily aspirin)

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided

Areas of concern_____ **Pain Intensity:** ____ Mild ____ Moderate ____ Severe ____ Other _____

Duration: ____ Constant ____ Intermittent ____ With certain motions **How long does the discomfort last** ___min ___hrs ___days

When did you first notice pain or discomfort? _____ **What activities are difficult/painful?** _____

What activities are helpful? _____ **Are you currently under the care of a health practitioner**? YES NO

Has there been a medical diagnosis? NO YES _____

What are your most frequent activities involved in work and home? ____ sitting ____ standing ____ lifting ____ other ___

In which part[s] of your body do you feel stress most often? *Check all that apply.* ____ Head ____ Neck ____Shoulders ____ Back____ Digestive ____ Extremities ____ Other _____

Previous injuries, including broken bones, NOT requiring surgery: _____

OFFICE ONLY:
____ Welcome ____ Thank You
____ Input ____ Accounting

Please Complete Back

Comfort Zone Massage, LLC
Client Health History and Consent Form

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session[s], 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 or bodywork should not be construed as a substitute for medical examination, diagnosis or 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/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 condition, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updates 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 payment of the scheduled appointment. **I acknowledge that this information I confidential, and that no personal data shall be released to anyone without my expressed permission [following the laws of confidentiality].**

Disclosures:

While we are aware that emergencies occur, please know that your appointment covers a 60-minute time slot in our book. Your consideration in letting us know ahead of time of any problem will allow us to schedule another person. Thank you.

Cancellation Policy: Please give us 12-hours notice if you need to cancel or reschedule.

Lateness Policy: If you are late for your appointment, we may need to shorten your session or reschedule your appointment so that we can stay on time for others. If we are late, you will receive your full time.

No Show Policy: First time we will attempt to work with you. The second time, you will be asked to pay 50% of the session. Any time thereafter, you will be billed at the full price of the session.

Hot Stone Massage Informed Consent [Condensed Version]

I hereby request and consent to the performance of hot stone massage on me [or the client named below, for whom I am legally responsible] by any Comfort Zone massage therapist. I understand that hot stone massage involve heating stones, then using those stones during the course of massage, either by the massage therapist placing those stone on me to warm and relax muscles, or by the massage therapist holding those stones in their hands and then massaging me with those stones. I understand that:

1. Hot stone massage is a ***generally safe method of massage***, but that it may have some side effects, including burns or related scarring as a result of the contact of the hot stones with my skin.
2. A variety of ***medical conditions*** which I might have, and which my therapist has neither the training, nor the legal right to interpret, could increase the risk of burns for me.
3. The ***sensitivity of my skin type*** may also impact the risk associated with burns and scarring.
4. Certain ***medications*** make a person more sensitive to heat exposure.

I understand that a full disclosure document is available to me and that it describes the major risks of hot stone massage, other side effects and risks that my occur. I do not expect the massage therapist to be able to anticipate and explain all possible risks and complications of hot stone massage. I wish to rely on the massage therapist to exercise judgment during the course of the hot stone massage, which at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____