Medical History for Initial Therapeutic Massage

Today's Date: _____ Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ Other Phone: _____
Email: _____ Can we add you to our email list? YES NO
Occupation: _____ Gender: _____ Age: _____ DOB: ____/____/____ Weight: _____
Referred to us by? _____ Name & contact number in case of emergency: _____
_____ Who is your medical doctor? _____
Date of last visit: _____ Reason: _____ Have you received massage/acupuncture/Chinese herbs in the past? _____ Date: _____ Reason: _____
Current Medications: _____
Supplements/Herbs: _____
Previous car accidents, falls, and/or surgery, with their dates: _____
_____
What is your primary reason for this visit? _____
_____
Have you received treatment for this? If so, what? _____ Did it help? _____

CIRCLE any symptoms or illnesses you have currently, CHECK any you have had in the past:

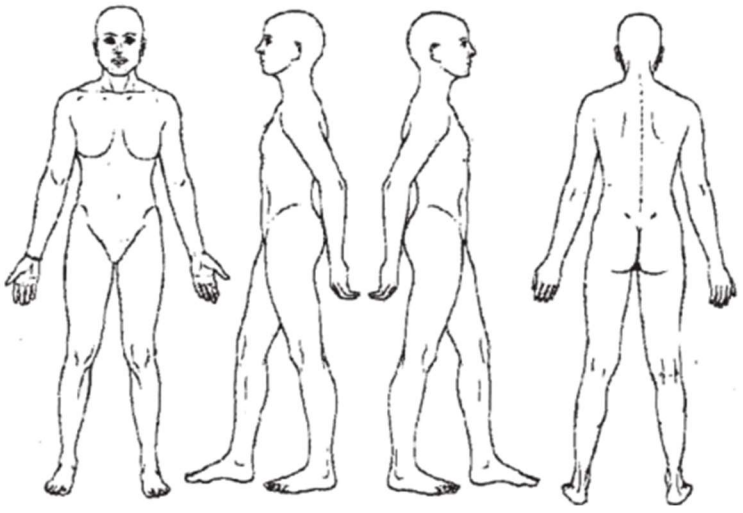
AIDS/HIV	Depression/Anxiety	Hepatitis B/C
Allergies	Diabetes/Pre-diabetes	Indigestion/Acid Reflux
Alcoholism	Ear/Nose/Throat	Insomnia
Arthritis	Easy bruising	Low energy
Asthma	Edema	Lymphedema
Back/neck problems	Epilepsy	Osteoporosis
Blood pressure (high/low)	Fertility issues	Poor memory/concentration
Cancer	Menstrual/Hormonal issues	Tuberculosis
Cholesterol	Gastrointestinal issues	Varicose veins
Deep vein thrombosis/blood clots	Headache/Migraine	Vertigo
	Heart disease	Venereal disease

Smoke? _____ Drink alcohol? _____ Caffeine? _____

Use the diagram to indicate the areas that currently bother you.

List any other conditions or comments you'd like for us to know:

_____
_____
_____
_____
_____
_____



Policies & Consent to Treatment for Therapeutic Massage

Cancellation Policy & Late Arrival

Channa Pickett Massage LLC is a small, independent business. Missed appointments are costly for us and prevent us from seeing other patients/clients. If you are unable to keep your appointment, please call us as soon as possible. If you do not reach us, leave a voice message, or send a text message.

For scheduling appointments and notifying appointment changes between Monday-Thursday, contact Monica Paredes at the Armonía Health cell: (919) 809-0576. Contact Channa Pickett at (919) 323-0535 for changes Friday-Monday.

We understand that unexpected events happen occasionally in everyone's life. To be effective and fair to all our clients, we maintain the following policies:

- 48-hours advance notice to change or cancel an appointment is encouraged.
- 24-hours advance notice to change or cancel an appointment is required. Clients who cancel an appointment with 24-hours notice or less or who do not come to a scheduled appointment will be billed 100% of the price of the scheduled service.
- Payment for a missed appointment is required before we can reschedule you for future appointments.
- All scheduled appointments will end at the scheduled time for us to stay on schedule. If a client arrives late, the practitioner will decide if there is enough time to start a session. Clients who arrive late for their scheduled appointment will be charged for the full session and will not receive a time extension.

Payment

Full payment is expected before or after treatment in the form of cash, credit/debit card, check, or Venmo to your practitioner. All clients, whether they have received treatment or booked an appointment, are bound by this policy without any prejudice or exemption.

Cupping Therapy & Gua sha

Cupping therapy or gua sha may be incorporated in your treatment, due to the nature of the therapies which break adhesions and lift stagnant blood to the surface of the skin, discoloration may appear on the skin. Discoloration marks vary from person to person and generally dissipate within a week of treatment. This is a normal reaction and part of the healing process.

Draping

Draping will be used during the session. Only the area being worked on will be uncovered.

Minors

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

HIPPA Policy

HIPAA regulations require all practitioners to obtain a signed release form from their patient/client before taking any information about them. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records. By signing below, you give permission for your practitioner to take notes including health history/ medical and/or personal information that you choose to disclose to the practitioner as the practitioner deems necessary. You understand this information may be shared under legal obligations or with another medical professional or health care provider to enhance your quality of care. Channa Pickett Massage LLC and Armonía Health LLC work with a cooperative model, so your file is shared if you see another practitioner at this practice and your signature on this form gives permission to the practitioners at Armonía Health LLC to speak to each other.

By signing below you agree to the following:

- I voluntarily request and consent to receiving massage therapy.
- I understand that the massage service offered is for the purpose of general wellness, stress reduction, and relief of muscular tension only.
- I do not have any injuries or conditions that prevent me from receiving massage therapy.
- I understand the importance of informing my massage therapist of all medical conditions and medications that I am taking, and that there may be additional risks based on my physical condition.
- I understand that massage therapists do not diagnose illness or disease, and nothing said during the massage should be construed as such.
- If I experience any pain or discomfort, I will immediately inform my therapist so that the pressure or techniques used can be adjusted to my comfort level. I will not hold my massage therapist responsible for any pain or discomfort I experience during or after the session.
- I understand the risks associated with massage therapy include but are not limited to: Superficial bruising, short-term muscle soreness, exacerbation of undiscovered injury
- I do not have any contagious conditions that may put my massage therapist or other clients at risk.
- I understand that I or the massage therapist may terminate the session at any time.

Client Name: _____ Date: _____

Client Signature: _____

Parent/Guardian Name & Signature: _____

Therapist's Signature: _____