RAYS OF HOPE MASSAGE

PATIENT DATA

PATIENT NAME | HOME PHONE | WORK PHONE

CELL PHONE | AT WHICH NUMBER WOULD YOU PREFER TO BE CALLED?

REFERRED BY:

STREET ADDRESS | CITY | STATE | ZIP

BIRTHDATE | AGE | OCCUPATION

EMERGENCY NUMBER | RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN | PHYSICAN'S ADDRESS | PHYSICIAN'S PHONE

My signature is an acknowledgment that I have read the billing policy attached and agree to abide by the same.

PRINT NAME | SIGNATURE | DATE

IF PATIENT IS A MINOR: Permission is hereby given by me to the doctors/massage therapists of this office to treat this patient. I am his/her legal guardian.

PRINT GUARDIAN NAME | SIGNATURE | DATE

VISIT DETAILS:

Do you suspect that you might be pregnant?

- ❑ Yes
- ❑ No

Are you currently taking any of the following medications?

- ❑ Blood Thinners
- ❑ Muscle Relaxants
- ❑ Birth Control
- ❑ Anti-inflammatory
- ❑ High Blood Pressure
- ❑ Pain Relievers
- ❑ Diabetes

Are you currently taking any other over the counter medications?

- ❑ Yes
- ❑ No

If yes, please explain: _____

Have you ever had any surgical procedures? Yes No If yes, please describe:

_____

PAST MEDICAL HISTORY

Please check the appropriate box for any of the following symptoms which you **now have** or **have had previously.** Please take your time and answer each question carefully. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

❑ Abdominal Pain	❑ Carpal Tunnel Syndrome	❑ Scoliosis	❑ Numbness/Tingling
❑ Arthritis	❑ Allergies	❑ Bursitis	❑ Diabetes
❑ Fibromyalgia	❑ High blood pressure	❑ Headaches	❑ Gout
❑ Insomnia	❑ Heart attack/disease	❑ Hernia	❑ Seizure
❑ Varicose veins	❑ Sprain/strain	❑ Sciatica	❑ Asthma
❑ Cancer	❑ Dizziness/Fainting	❑ Ulcer	❑ Fatigue
❑ Anemia	❑ TMJ	❑ Stroke/Aneurysm	❑ Fracture

Back pain: Neck Mid back Low back Sacroiliac Tailbone

Are there **any other medical conditions** your therapist should be aware of? _____

_____

Do you wear contacts? Yes No

Do you have any of the following today?

Sunburn	Irritated skin rash	Severe pain	Poison Ivy
Headache	Cold/Flu	Inflammation	Open cuts, bruises, burns

Have you ever had a massage before? Yes No

Type of massage experienced: Deep Tissue Swedish Other (please describe): _____

_____

What are your goals/expectations for this therapy session?

_____

_____

Please read the following and sign below: I understand that massage is not a replacement for medical care and that no diagnosis will be made. I (the therapist) reserve the right to refuse or discontinue treatment according to medical conditions, noncompliance with ethical codes or sexual misconduct. I attest that all of the above is true and to the best of my knowledge.

Signature: _____ Date: _____

RAYS OF HOPE MASSAGE

MASSAGE THERAPY INFORMED CONSENT

I hereby request and consent to the performance of massage therapy on me (or on the patient named below, for whom I am legally responsible) by the therapist of Rays of Hope Massage.

I have had an opportunity to discuss with the massage therapist the nature and purpose of massage therapy. I understand that results are not guaranteed. I have been informed of other health care options that may also help my condition.

I understand and am informed that in the practice of massage therapy there are some risks to treatment, including but not limited to: bruising, muscle soreness and swelling. I do not expect the therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that payment is due in full at the time of treatment.

PATIENT NAME PRINTED: _____

PATIENT SIGNATURE: _____DATE: _____

WITNESS NAME PRINTED: _____

WITNESS SIGNATURE: _____DATE: _____