Kneady By Nature

Today's date: _____

How did you hear about us? _____

CLIENT INFORMATION AND CONSENT FORM

An accurate health history ensures that it is safe for you to receive a massage treatment and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

First Name:_____ Last Name:_____

Street:_____City _____State____
Zip_____

Date of Birth:_____

Phone Numbers: Home: _____ Cell: _____

Email Address: _____

Occupation:_____

Are you under a physican's care?: Yes No If yes, please explain

_____

_____

What is your major area of concern that you would like treated?

_____

_____

Lifestyle Questions

Regular eating habits Yes ( ) No ( ) Do you take vitamins: Yes ( ) No ( )

Do you take prescribed medications: Yes ( ) No ( )

Type: _____ Frequency: _____

Regular exercise: Yes ( ) No ( )

Type: _____ Frequency: _____

High Stress: Yes ( ) No ( ) IF YES: At home ( ) At work ( ) Both ( )

Have you received care from any of the following: (circle) physiotherapist, chiropractor, massage therapist, naturopath, other:

_____

_____

Have you had surgery in the past? If yes, for what?

_____

_____

Have you had any fractures/sprains in the past? If yes, where?

_____

_____

Have you had any serious illnesses in the past? If yes, what?

_____

_____

Did the current injury result from a motor vehicle accident or workplace injury?

Yes ( ) No ( )

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of the State of Florida. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended, by my therapist.

___I understand that massage is in no way a sexual act and will not be conducted as such. I acknowledge that I can terminate the session at any time. I understand that if my massage therapist feels uncomfortable or threatened, they can terminate the session at any time. Should this misconduct occur I am responsible for the entire cost of service before I leave.

I acknowledge that the therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment, there can be risks and those risks have been explained to me and I assume those risks. I understand that at any time, I may withdraw my consent and treatment will be stopped.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers, only when necessary and only with a prior verbal request.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I also understand that I am responsible for any charges incurred during my treatment.

Patient Name_____

Signature of Patient/Guardian _____

Date Signed _____