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| Policies, Privacy, and Consent FormPlease take a moment to carefully read the following information and sign where indicated: |

**Note: You are responsible for letting the therapist know whether the pressure levels are too deep or too light as well as if the pace is suitable for you. The therapist can feel the muscles however only you can tell the sensation level in the muscle. Communication is Very important when receiving bodywork. Feel free to ask questions and voice any concerns you may have.**

**General Policies**

1. Payment is due at the time of the massage appointment in the form of cash, check or credit card
2. Appointments are reserved for the time slot chosen. Clients arriving late to their appointment will receive the remainder of their appointment time or have the opportunity to reschedule.
3. There is a 24 hour cancellation policy. Clients may be charged for missed appointments if cancellations were not made before appointment time.
4. Client records are kept secure and confidential. (See Privacy Policy, below)
5. To protect your privacy and the privacy of the massage therapist the use of cell phones, cameras, camcorders, or other portable devices are not allowed during the massage session, except in special circumstances agreed upon beforehand with the massage therapist.
6. Massage sessions may be terminated at any time the massage therapist has reason to believe that a client is sexualizing the massage, or uses inappropriate or threatening language or behavior.
7. The office follows the Code of Ethics and Standards of Practice of the American Massage Therapy Association ([www.amtamassage.org](http://www.amtamassage.org)) and regulations set forth by the Mississippi State Board of Massage Therapy ([www.msbmt.state.ms.us](http://www.msbmt.state.ms.us))

**Privacy Policy**

Your massage therapy records are kept confidential. No portion of your medical history or treatment will be shared with an individual or released to third parties, including health care providers and insurance companies outside of Attune to You without prior written permission. Records may be surrendered if required by law or subpoena.

**General Agreement and Consent** (read and initial)

**If you have a medical condition or specific symptoms, massage therapy may be problematic. A referral from your primary health care provider may be required prior to treatment being provided.**

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| initial | I understand that I have the right to discontinue/adjust my massage sessions or refuse any type of service for any reason. I also understand that my therapist has the same rights and a duty to provide a safe and professional environment that is geared towards my health and wellbeing, in doing this he/she can discontinue providing services to me for any reason. |
|  |
| initial | I understand that the massage therapist does not diagnose, prescribe medical treatment or medications, or perform spinal manipulations. Massage is not to be used as a substitute for medical examination or diagnosis and it is recommended that I see a physician for any ailments that I might have. |
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| initial | I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. |
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My signature below confirms my agreement to the general policies, privacy policy, and consent statements above.

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| Click here to enter text. |  | Click here to enter text. |
| **Print Name** |  | **Client’s Signature** |
| Click here to enter a date. |  | Click here to enter text. |
| **Date** |  | **Therapist’s Signature** |

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| Client Intake FormThe MS State Board of Massage Therapy dictates that this form must be filled out by all massage clients prior to receiving body work. This form will be retained on file for two years. All information is important in order to provide the best treatment plan available. Please read carefully and fill out all that apply. |

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| Client Information |
| Date: | Click here to enter a date. |
| Last Name: | Click here to enter text. | **First Name:** | Click here to enter text. | **MI:** | Initials |  |
| DOB:  | MM/DD/YYYY | **Age:** |  Enter here | **Gender:** | **[ ]  Male** | **[ ]  Female** |  | **[ ]  Minor** |  |
| Address: | Click here to enter address. | **City:** | Click here to enter text. | **State:** |  Enter here | **Zip:** | Click here |  |
| Home Phone: | Click here to enter | **Cell:** | Click here to enter | **Work:** | Click here to enter | **Ext** | Click here |  |
| Primary Email: | Click here to enter email address. | **Alternate:** | Click here to enter secondary email |  |
| Emergency Contact: | Click here to enter text. | **Phone #:** | Click here to enter |  |
| Business/Employer: | Click here to enter text. | **Type of Work:** | Click here to enter text. |  |

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| ***Health History*** |
| **Are you pregnant?** | [ ]  Yes [ ]  No | \*Please fill in +pregnancy form if you have not already |
| Are you currently experiencing any of the following conditions? |
|  | [ ]  | Cold/Flu/Pneumonia | [ ]  | Inflammation | [ ]  | Fever | [ ]  | Infection | [ ]  | Contagious Disease |
|  | [ ]  | Blood Clots/Phlebitis | [ ]  | Dermatitis/Eczema | [ ]  | Open Wound/Sore | [ ]  | Trouble Breathing |  |
| ***Please check (√) any of the following conditions below that currently affect you or that you have experienced in the last 2 years.*** |
| [ ]  | Allergies to | Click here to enter text. | Medication | Click here to enter text. |
| [ ]  | Cancer | (Type)Click here to enter text. | Medication | Click here to enter text. |
| [ ]  | Blood Disorders | (Type)Click here to enter text. | Medication | Click here to enter text. |
| [ ]  | Asthma or other breathing disorders | Medication | Click here to enter text. |
| [ ]  | Seizure Disorder | Medication | Click here to enter text. |
| [ ]  | Kidney Disease | Medication | Click here to enter text. |
| [ ]  | Diabetes | Medication | Click here to enter text. |
| [ ]  | Sleep Disorder | Medication | Click here to enter text. |
| [ ]  | Chronic Fatigue | Medication | Click here to enter text. |
| [ ]  | Migraines/Headaches | Medication | Click here to enter text. |
| [ ]  | Lupus | Medication | Click here to enter text. |
| [ ]  | Depression | Medication | Click here to enter text. |
| [ ]  | Anxiety/Panic Attacks | Medication | Click here to enter text. |
| [ ]  | Varicose Veins | Medication | Click here to enter text. |
| [ ]  | Fibromyalgia | Medication | Click here to enter text. |
| [ ]  | Skin Condition  | (Type)Click here to enter text. | Medication | Click here to enter text. |
| Other Medical Conditions: |  |
| Describe any surgeries (5 yrs), accidents (2 yrs), injuries (12 mo) |
| **Year** | **Body Part** | **Condition** | **Treatment Received** | **Recovered** |
| Ex. 2010 | Left Femur, right arm | Car accident/ broken | Surgery/physical therapy | Yes |
|  Enter here | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. |
|  Enter here | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. |
|  Enter here | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. |
|  Enter here | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. |

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| I have answered the above questions to the best of my ability. I acknowledge that massage therapy does not include medical diagnosis and that I should see an appropriate health care provider to diagnose and treat medical problems. I give my consent for the massage session. |
| **Signature:**  | Click here to enter text. | **Date:** | Click here to enter a date. |  |

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| **Reason for visit? [ ]  Relaxation [ ]  Athletic Treatment [ ]  Pain Management** |
| Have you ever received a professional massage? | [ ]  Yes | [ ]  No | How often? | Choose an item. |
| What results would you like to achieve? | Click here to enter text. |
| What kind of pressure do you prefer? | [ ]  Light | [ ]  Medium | [ ]  Firm  | [ ]  Unknown |  |
| Do you wear contacts?  | [ ]  Yes | [ ]  No | Do you exercise?  | [ ]  Yes | [ ]  No | If yes, how often? | Choose an item. |
| How much water did you drink today?  | Click here to enter text. |
| List ALL medications taken in the last 24 hours and what they treat (vitamin, herb, pharmaceutical) |
| Click here to enter text. |
| Hobbies, Exercises, Relaxing Activities: | Click here to enter text. |
| Describe any chronic, ongoing pain that you deal with on a regular basis: |
| Click here to enter text. |
| When did your symptoms appear?  | Click here to enter text. |
| What treatment have you already received for your condition?  |
| [ ]  Medication | [ ] Surgery | [ ] Physical Therapy | [ ]  Chiropractic Care | [ ]  None |  [ ] Other |  |
| Type of Pain: |  |  |  |  |  |  |
|  | [ ]  Chronic | [ ]  Sharp | [ ]  Dull | [ ]  Throbbing | [ ]  Numbness | [ ]  Aching | [ ]  Shooting | [ ]  Acute |
|  | [ ]  Burning | [ ]  Tingling | [ ] Cramps | [ ]  Stiffness | [ ]  Swelling | [ ]  Other |  |
|  | Frequency: | Click here to enter text. |  |
| Does it interfere with:  | [ ]  Work [ ]  Sleep [ ]  Daily Routine [ ]  Recreation |
| Activities that are painful to perform: | [ ] Sitting [ ] Walking [ ] Standing [ ] Bending [ ] Laying |
| Are you currently under the care of a physician?  | [ ]  Yes [ ]  No | Chiropractor? | [ ]  Yes [ ]  No |
| **I give permission to contact any of these health care providers in order to best support my treatment.** |
| [ ]  Yes [ ]  No | Contact Name: | Click here to enter text. | Number: | Click here to enter text. |
| [ ]  Yes [ ]  No | Contact Name: | Click here to enter text. | Number: | Click here to enter text. |

**Office Use Only**

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| S O A P Notes | Client Name: |  Click here to enter text. | DOB: |  MM/DD/YYYY | Date: |  Click to enter date. |
| Date of Injury: |  Click to enter date. | Meds: |  Click here to enter text. | Goal: |  Click here to enter text. |
|   |
| S | Click here to enter text. |
| O | Click here to enter text. |
| A | Click here to enter text. |
| P | Click here to enter text. |
|  | Therapist’s Signature: | Click here to enter text. | Date: | MM/DD/YYYY |
| LEGEND | × Adh | ⁄ elev | • TeP | ≈ SP | ≡ HT | ↔ Long | \* Infl | Δ Change | ⊗ TP | ≠ numb | **₱** Pain |

***Office Use Only***

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| Progress Notes | Date: MM/DD/YYYY |
| Changes: Click here to enter text. |
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| S | Click here to enter text. |
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| A | Click here to enter text. |
| P | Click here to enter text. |
|  Date:  | MM/DD/YYYY |
| Therapist’s Signature:  | Click here to enter text. |

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|  Date: | MM/DD/YYYY |
| Therapist’s Signature:  | Click here to enter text. |

 | Additional Notes:Click here to enter text. |

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| P | Click here to enter text. |
| Date: | MM/DD/YYYY |
| Therapist’s Signature:  | Click here to enter text.  |

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| Progress Notes | Date: MM/DD/YYYY |
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| A | Click here to enter text. |
| P | Click here to enter text. |
|  Date: | MM/DD/YYYY |
| Therapist’s Signature:  | Click here to enter text. |

 | Additional Notes:Click here to enter text. |