Massage Therapy Sign In

Name:_____ Phone ☎: _____

What are your goals for today's session: Relaxation: _____ Pain/Tension relief: _____ Flexibility: _____

Other: _____ ☐ Medical ☐ Deep Tissue ☐ Heat / Ice ☐ Paraffin Dip ☐ Aroma Therapy ☐ Foot Soak

Areas of interest & character of work/massage to be performed

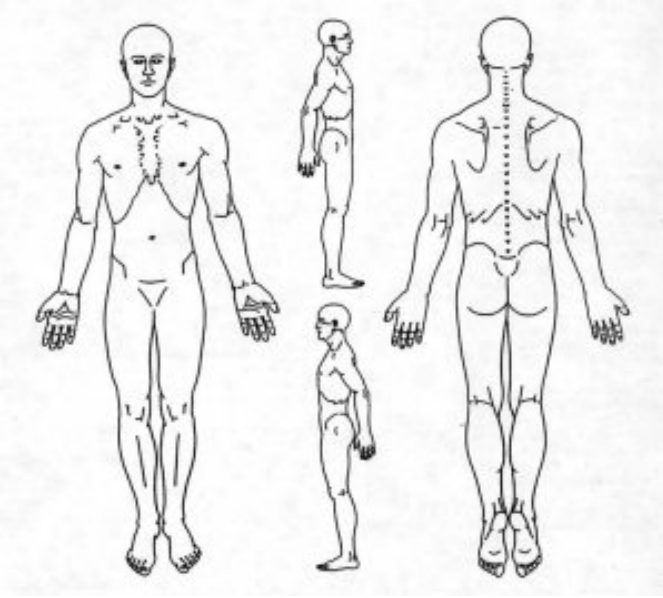
Focus on:

Avoid:

i.e. Back, Hands, Feet, Head, Arms, Legs, Glutes, Same, etc

Also include things you would like changed compared with your last visit: deeper/lighter pressure. slower/faster, more/less stretching, trigger points, reflexology, etc. **(☐ Feather light touch)**

Precisely mark the areas of symptoms



Name or circle your conditions below and circle the severity "0" being perfect and "10 being worst possible.

Headache/Migraine	0_1_2_3_4_5_6_7_8_9_10
Neck	0_1_2_3_4_5_6_7_8_9_10
Mid Back	0_1_2_3_4_5_6_7_8_9_10
Low Back	0_1_2_3_4_5_6_7_8_9_10
_____	0_1_2_3_4_5_6_7_8_9_10
_____	0_1_2_3_4_5_6_7_8_9_10

Have you noticed any changes since your last visit?

What makes your complaints better or worse?

_____

Since your last visit

(including those not the area of focus)

Any new conditions *(including: Cold/Flu, Inflammation, Cuts/Burns/Bruises, Rash/Poison Ivy, Sunburn, Sprains/Strains or other Injuries)*	Yes/No	Currently under a Dr's care	Yes/No
		Is it affecting your daily routine	Yes/No
		Have you seen another therapist	Yes/No
New Accident/Injury	Yes/No	**Taking any Medicine/Supplements**	Yes/No
Have you seen a Dr on these issues	Yes/No	If you answered yes describe in notes below.	

If you are missing work when was the last date worked: _____

Notes:_____

_____

_____

_____

Signed: _____ Date: _____ **(STOP)**

*****Therapists Use ONLY*****

SOAP/CARE Notes* Date: _____Therapist_____

____ Basic/Swedish Massage (97124); ____ Manual Therapy (97140 - Advanced Massgae Therapy Techniques); ____ Heat / Ice (97010)

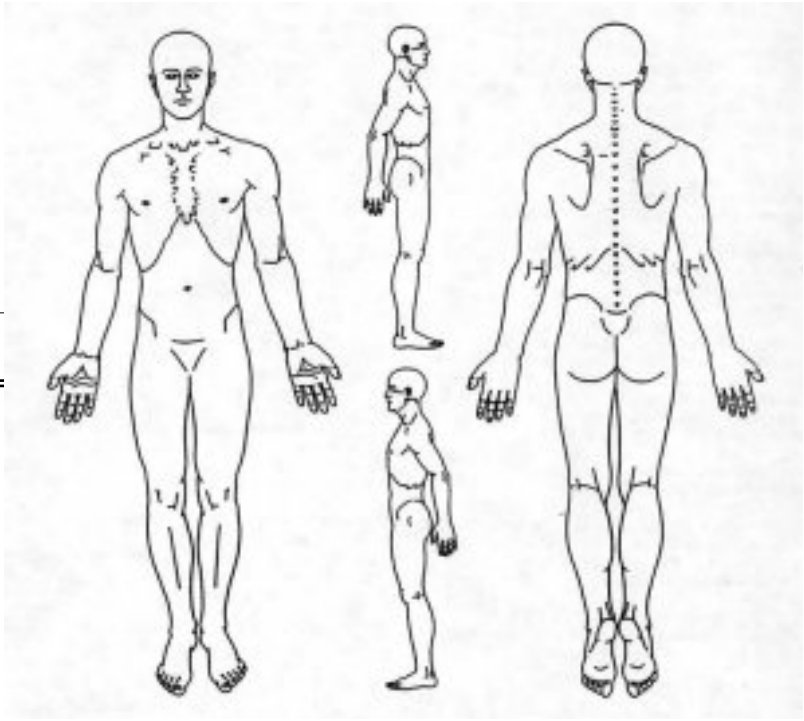
Referral Diagnosis / ICD: _____

(40) – Manual Therapy	PS – Palmar Stretches	MFR – Myofascial Release	Sp – Spasm
(24) – Basic/Swedish	KK – Kneading	CST – Cranial Sacral	TP – Trigger Point
SwM – Swedish Massage	ART – Active Release	Pol – Polarity	I – Inflammation
bilat – both sides	FmS – Forearm Stripping	DTS – Deep Tissue Sculpting	noc – Nocturnal
EC – Elbow Compression	ES Elbow Stripping	LD – Lymphatic Drainage	px – pain
® – Right	TS – Thumb/Finger Stripping	(M) – Massage	ITB – Iliotibial Band
PC – Palmar Compression	ACU – Acupressure	GFB – General Full Body	xff/cff – Cross Fiber Friction

SHARP: + / - (Size:Heat:A loss of function:Redness:Pain)

For Diagram:

A – Adhesion
~ – Spasm
' – Tender point
O – Tight Band
E – Edema
X – Trigger Point
P – Pain



SOAP

☐ Medical

Homework:

*** Subjective; Objective; Assessment & Plan – C =condition of client; A=action taken; R=response of client; E=evaluation**

Client information: Massage Therapy

Name: _____ Date of Birth: _____

Address: _____Local / Frequent Visitor? _____

City: _____State: ____ Zip: _____

Permanent Address: _____Zip: _____

Phone: (H)_____ (W)_____ (Textable)_____

Email Address:_____

Occupation: _____

How did you hear about us: _____

Emergency Contact: _____ Phone:_____ Relationship: _____

Have you had massages before (describe) _____

When was your last professional massage _____

Exercise (type & frequency) _____☐ Training

List any medications and supplements you are taking _____

_____

Are you under a Dr's Care* Yes / No : Physician:_____ Phone: _____

**If you are being referred by a physician, please bring your referral letter with diagnosis (Including ICD) – May be required to be covered by insurance*

Do you currently or anytime in the past have any of the following conditions

(Check for yes)	☐ Broken Bones	☐ Hepatitis	☐ Seizures
☐ Addiction	☐ Bruise Easily	☐ High / Low BP	☐ Spinal injuries
☐ Allergies/Sensitive to perfumes, lotions, or oils	☐ Cancer	☐ Mental / Emotional Distress / PTSD (Triggers in massage?)	☐ Surgery
	☐ Circulation Problems		☐ Stroke
	☐ Diabetes		☐ Ticklish
☐ Accident	☐ EDS	☐ Mononucleosis	☐ Tuberculosis
☐ AIDS/HIV	☐ Fainting	☐ Osteoporosis	☐ Varicose Veins
☐ Arthritis	☐ Fibromyalgia	☐ Pregnant/Trying	☐ Weak tissues or joints
☐ Asthma	☐ G.I. Problems	☐ Scoliosis	☐ Whiplash
☐ Back/Neck Issues	☐ Headaches	☐ Skin Sensitivity	
☐ Blood Clots	☐ Heart Disease	☐ Sprains	

If you checked yes, please describe, give relevant dates, and list other health problems below:

_____

Smoke ____ packs/week | Drink ____ glasses of water per day

Drink ____ Alcohol drinks/week | Drink ____ servings of caffeine/week

Recreational Drugs: Never – Occasionally – Frequently _____

Do you have a special diet? Low Fat / Low Carb / Vegetarian / _____

Read and sign back of form. **Pg. 1 of 2** **(Over)**

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- I understand that massage is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing energy flow.
- I understand the massage therapist does not diagnose illness, disease, or any other physical or pharmaceuticals/supplements
- I understand that massage therapy is not a substitute for medical treatment and/or diagnosis, and that it is recommended that I see a physician for any ailments that I may have, and before I start any exercise regiment.
- The massage therapist will only provide massage in the course of work trained.
- If the client lists any contraindications for therapeutic massage, the therapist will be granted the right to contact there physician for medical release prior to massage.
- I understand that any sexually suggestive remarks or advances made by me will result in immediate termination of the session. I will be liable for payment in full.
- I understand that if I cancel my appointment without giving 24-Hour advanced notice, I will be liable for the full payment for that session.
- All information is strictly confidential and will not be sold or given out. It may be shared with insurance companies and insurance companies on file.
- I will communicate with the therapist during the massage to indicate pain, pace pressure, and other issues during the massage so the therapist can tailor the session and make it appropriate and effective for me the client

I would like to receive promotions from this office/therapist via: Email, Phone, Mail, Social Media
If it is important that we not contact you be a particular method, please inform your therapist.

I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST UPDATED ON MY PHYSICAL HEALTH.

SIGNATURE _____ DATE _____

If the client is under the age of 18, the parent or guardian must sign below authorizing care, attesting that the information provided is accurate and true, and will be financially responsible for all services performed.
Parent/Guardian's Printed Name: _____
Relationship: _____

_____ _____
Signature of parent/guardian Date

(Office Use) Therapist _____ NOTES: