Karen Medina, LMP
Therapeutic Massage
Northwest Body Balance

Phone: (425) 442-0947
Fax: (877) 841-5134

"Support, Balance, Vitality"

CONFIDENTIAL HEALTH INFORMATION

Patient Information

Patient Name_____ Date_____

Date of Birth_____

Address_____ City_____

State_____ Zip Code_____

Home Phone (_____) _____ Work (_____) _____

Cell (_____) _____ E-mail _____

How did you hear about me? _____

How may I contact you? Please circle: E-mail Mail Phone

Would you like to receive newsletters/occasional correspondence e-mail from me? ☐Yes ☐No

Employer_____ Work Address_____

Occupation_____

Emergency Contact_____ Phone_____

Name of Referring
Physician_____Address_____

Phone (_____)_____ Fax (_____)_____

License #MA00017640

HEALTH HISTORY

Please use 'C' (current), 'P' (past) or 'S' (sometimes) for the following conditions:

___HIV/AIDS
___Spasms/Cramps
___Sprains/Strains
___Osteoporosis
___Postural Deviations
___Gout
___Osteoarthritis
___Rheumatoid Arthritis
___TMJ
___Cysts
___Bursitis
___Plantar Fascitis
___Torticollis
___Tendonitis

___Anemia
___Hemophilia
___Hypertension
___Low Blood Pressure
___Raynaud's Disease
___Varicose Veins
___Heart Conditions
___Heart Attack
___Blood Clots/Phlebitis
___Circulatory Problems
___Diabetes
___Cancer
___ALS
___Multiple Sclerosis

___Fungal Infections
___Acne
___Impetigo
___Dermatitis/Eczema
___Rosacea
___Psoriasis
___Open Wound or Sore
___Rashes
___Warts/Moles
___Athletes Foot
___Ringworm
___Herpes
___Kidney Disease
___Bladder Infections

___Whiplash
___Carpal Tunnel
___Sciatica
___Thoracic Outlet
___Headaches
___Migraines
___Leg Pain

___Parkinson's Disease
___Bell's Palsy
___Neuritis
___Spinal Cord Injury
___Stroke
___Trigeminal Neuralgia
___Epilepsy and Seizures

___Post-Op
___Edema
___Substance Abuse
___Other
If other, please explain:
_____
_____

___Arm Pain/Shoulder Pain
___Low Back Pain
___Mid Back Pain
___Hip Pain
___Fibromyalgia
___Chronic Fatigue
___Pneumonia
___Asthma
___Trouble Breathing
___Dizziness
___Sinusitis
___Seasonal Allergies
___Skin Allergies
___Sprains/Strains

___Numbness/Tingling
___Ulcers
___Irritable Bowel Syndrome
___Colitis
___Gallstones
___Lupus
___Diarrhea
___Constipation
___Gas/Bloating
___Indigestion
___Disc Problems
___Diverticulitis
___Excess Stress
___Anxiety/Panic Attacks

___Lupus

___Insomnia

For Women only:

___Pregnant
___Amenorrhea
___Menopause

___Trying to get pregnant
___Menstrual Cramps
___Irregular Periods

___Excessive Bleeding
___PMS

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Are you <u>currently</u> contagious with any of the following: Herpes, Scabies, Cold/Flu, Shingles, or other contagious condition? _____

<u>Accidents, Injuries or Surgeries:</u>

Less than 5 years ago:_____
More than 5 years ago:_____

Are you currently receiving medical or chiropractic care? ☐Yes ☐No
If yes, please explain: _____
_____

Are you taking any medications (prescription and over-the-counter)? ☐Yes ☐No
If yes, please list all medications:_____
_____

Do you wear contact lenses: ☐Yes ☐No

Is this your first professional massage? ☐Yes ☐No
If no, how frequently do you get a massage?_____

What do you especially like or dislike about massage? _____
_____

What do you hope to achieve from today's massage?_____
_____

<u>Please read and sign the following:</u>

I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will inform the massage practitioner of any changes in my physical condition prior to massage. I am also aware that payment is due at the time of service.

Last minute cancellations, or missed appointments with less than 24 hours notice will be charged $70.00.

_____ _____
Client Signature Date

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PATIENT PRESENT COMPLAINTS

Please describe your current problem: _____
_____

How did the problem begin?_____
_____
_____

Date it began _____

What makes it better? _____

What makes it worse?_____

Any range of motion restrictions? _____

What treatment(s) have you had for this condition?_____
_____

How bad is your pain? 1 2 3 4 5 6 7 8 9 10
No pain Unbearable pain

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Shooting Throbbing Dull Stabbing
Burning Numbness Soreness Tingling

Can you perform your daily ***home*** activities: without pain with pain
Explain _____

Can you perform your daily ***work*** activities: without pain with pain
Explain _____

How is the quality of your sleep?_____ Hours of sleep lost _____

What are your goals with massage therapy?_____
_____

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CLIENT POLICIES AND PROCEDURES

Please read and sign below. A copy will be given to you upon request.

My requirements of clients:

1. **A 24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to provide a 24 hour advance notice you will be charged the full amount of $70 for your appointment. Emergency cancellations are considered at the practitioner's discretion (poor weather conditions, sickness).

2. **No-shows**
   Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for $70 for their "missed" appointment.

3. **Late Arrivals**
   If you arrive late, your session may be shortened in order to accommodate others whose appointment follows yours. Depending upon how late you arrive, I will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Out of respect and consideration to the therapist and other clients, please plan accordingly and be on time.

4. Be present during the massage (not under the influence of alcohol or drugs).

5. Provide a truthful health history and submit updates when necessary.

6. Payment is expected at the time service is rendered. Cash and checks are accepted. Fees for bounced checks due to insufficient funds are the client's responsibility and must be paid by the client. The practitioner will receive preferential status to receive payment as soon as funds are deposited into the account.

7. Sexual harassment is not tolerated. If the practitioner's safety feels compromised, the session is terminated immediately.

7. Clients are clean and showered the same day as the massage.

8. A client can be sent home if it is determined by the practitioner that massage is contraindicated for a medical condition.

9. As I have a home based practice, I screen all clients prior to scheduling their first massage with me. I provide ethical therapeutic massage that meets the standards of ABMP, AMTA and Washington State. I have a right as a therapist to refuse service to anyone should I feel the need to do so, and I do this as a safety precaution.

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What clients can expect from me:

1. I provide each person a competent and professional session each time at each appointment, addressing the client's specific needs for that session.

2. I am available 9:30 am - 3:00pm Monday, Tuesday, Wednesday and Fridays, Tuesday/Friday evenings from 6:00-7:30pm,and Saturdays from 9am-2pm. A message may be left on my voice-mail after hours and I will return calls within 24 hours unless I am out of town.

3. Clients are treated with respect and dignity.

4. I perform services for which I am qualified and able to do, referring to appropriate specialists when work is not within my scope of practice.

5. I keep accurate records and review charts before each session.

6. I respect all clients regardless of their age, gender, race, national origin, sexual orientation, religion, socio-economic status, body type, or political affiliation.

7. If I need to cancel an appointment, I do so within 24 hours whenever possible. If an emergency or illness arises and I cannot keep an appointment, I provide a 50% discount with the client's next session.

8. My equipment and supplies are clean and safe.

9. Personal and professional boundaries are respected at all times.

10. Privacy and confidentiality are maintained at all times.

12. Clients are draped with a sheet at all times during the session. Only the parts of the body being worked on are exposed at any time. The genitals are never exposed or massaged.

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Informed Consent for Massage Therapy

I, _____(client) understand that massage therapy provided by Karen Medina,LMP(massage practitioner) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.

The general benefits of massage, possible contraindications, and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage practitioner does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage practitioner of all my known conditions, medical conditions and medications, and I will keep the massage practitioner updated on any changes.

I understand the therapist's policies and agree to abide by them.

_____ _____
Client Signature Date