Molly Messmer LMT
Lic. #MA60777805
(360) 477-2492
mollymessmerlmt@gmail.com

## Client Contact Information

Client Name:_____Date:_____

Date of Birth:_____ Gender:_____

Address:_____

_____

Phone:_____

Email:_____

Referred by:_____

Emergency contact:_____Phone:_____

Physician/Health-care Provider name:_____Phone:_____

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes □ No □
If yes, please describe_____

_____

Do you have a physician referral/prescription? Yes □ No □
Are you seeking insurance reimbursement*? Yes □ No □
If yes, please let me know so I can provide the necessary documentation – *I do not bill insurance nor am I a provider for any insurance plan.

## Massage Information

Have you ever received professional massage/bodywork before? Yes □ No □
How recently?_____
What kind of pressure do you prefer? (please circle) Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?_____

_____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes □ No □
Explain:_____

_____

List the medications you currently take:_____

_____

_____

Are you pregnant? Yes □ No □ If yes, how many weeks? _____
Are you under doctor/midwife care Yes □ No □

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## Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema, lymphedema

Please answer honestly, as massage may not be indicated for the above conditions.
Please indicate (circle) conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain_____
Current Past Muscle or joint stiffness_____
Current Past Numbness or tingling_____
Current Past Swelling _____
Current Past Bruise easily_____
Current Past Sensitive to touch/pressure_____
Current Past High/Low blood pressure_____
Current Past Stroke, heart attack_____
Current Past Varicose veins_____
Current Past Shortness of breath, asthma_____
Current Past Cancer_____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain)_____
Current Past Epilepsy, seizures_____
Current Past Headaches, Migraines_____
Current Past TMJ, jaw clenching/grinding_____
Current Past Dizziness, ringing in the ears_____
Current Past Digestive conditions (e.g. Crohn's, IBS)_____
Current Past Gas, bloating, constipation_____
Current Past Kidney disease, infection_____
Current Past Arthritis (rheumatoid, osteoarthritis)_____
Current Past Osteoporosis, degenerative spine/disc_____
Current Past Scoliosis_____
Current Past Broken bones/sprains_____
Current Past Allergies_____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions_____
Current Past Depression, anxiety_____
Current Past Memory Loss, confusion, easily overwhelmed_____
Comments:_____

_____

_____

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# Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)
I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____