Jeannine Bowman, LMT 23705 ***655 A St, Suite F*** ***Springfield, OR 97477***
541-505-2756

Client Contact Information: Today's Date: _____

Legal Name: _____ DOB: _____

Preferred Name (if different than above): _____

Preferred Pronouns (check all that apply): She___ He ___ They ___ Other: _____

Gender on Insurance/legal gender: Female ____ Male____

Mailing Address:_____

Phone: _____ Email: _____

Appointment reminders: ___ text message ___ phone/voicemail message

Electronic communications (phone/text/voicemail/email) to and from this office/practitioner are not encrypted or secure. Your confidential health information will not be discussed via text, voicemail, or email unless initiated by you.

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 ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐

If yes, please complete the Billing Information form. Type of insurance coverage for this claim:

__ Car Collision __Worker's Compensation __Private Health

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What kind of pressure do you prefer? __ Light __ Medium __ Firm

Any areas you would like special attention? _____

Any areas you would like massage avoided? _____

Are you allergic or sensitive to any creams or oils? _____

Communication:

At times, your massage therapist will check in on pressure during your massage. They may also let you know when they are transitioning from one area to another or when they are about to change techniques. Visiting during the massage may change the experience, but it is entirely up to you.

I prefer to talk for a couple of minutes then relax ___Yes ___ No ___ Sometimes

I prefer little to no talking during my massage ___ Yes ___ No ___ Sometimes

What are your goals/expected outcomes for receiving massage/bodywork? _____

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Occupational Questions

What is your main activity at work? Phone_____ Sitting _____Computer_____ Labor _____ Driving_____

Health Information

List your current symptoms (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:

_____

_____

What seems to aggravate the condition? _____

What seems to help the condition? _____

List the medications you are currently taking: _____
_____

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

Indicate any of the following health conditions that you ***currently*** have (massage may not be indicated for these conditions): ___Blood Clots ___Infections ___Congestive Heart Failure ___Contagious Diseases ___Edema

Please indicate conditions that you have or have had in the past. Explain the condition, and any treatment:

Current___ Past___ Muscle or joint pain _____
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___ Dizziness, ringing in the ears _____
Current___ Past___ Digestive conditions (e.g. Crohn's, IBS) _____
Current___ Past___ Gas, bloating, constipation _____
Current___ Past___ Kidney disease, UTI _____
Current___ Past___ Arthritis (rheumatoid, osteoarthritis) _____
Current___ Past___ Osteoporosis, degenerative spine/disc _____
Current___ Past___ Scoliosis _____
Current___ Past___ Broken bones _____
Current___ Past___ Diabetes _____
Current___ Past___ Endocrine/thyroid conditions _____
Current___ Past___ Depression, anxiety, PTSD _____
Current___ Past___ Memory Loss, confusion _____

Is there anything else relevant to your treatment today? _____
_____

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Consent for Therapy

To comply with informed consent I will discuss the following with you prior to your treatment:

- What to expect from your entire treatment.
- Proposed treatment plan and goal.
- Any contraindications or precautions for massage.

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, or gender identity/expression.

Please take a moment to read the following and sign where indicated:

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 understand that massage therapy can sometimes result in short term dizziness, malaise or localized bruising and given this information, I consent to treatment.

I also understand that massage and 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 and 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 and body work 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 understand that massage therapy is nonsexual in nature. Any inappropriate behavior such as illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be responsible for payment of the scheduled session.

I agree and adhere to the cancelation policy and will be responsible for charges if I fail to provide 24 hour notice if I cancel or change my appointment.

Understanding all of this, I give my consent to receive care.

Client Signature _____ Date_____

Consent for a Minor

I give my consent for my child / ward _____,
to receive massage therapy and or energy work. I verify that I have the legal authority to give this consent.
Parent/Guardian Signature_____ Date_____