Therapeutic Bodywork Solutions

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(281) 809–0707

Date: _____

Client Information

Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Contact Numbers: Home _____ Cell _____ Work _____

E-mail: _____ Contact via: ❑ Phone ❑ Email ❑ Text Message

Referred by: _____ Phone (____) _____

In case of emergency: _____ Phone (____) _____

Occupation _____ ❑ Male ❑ Female

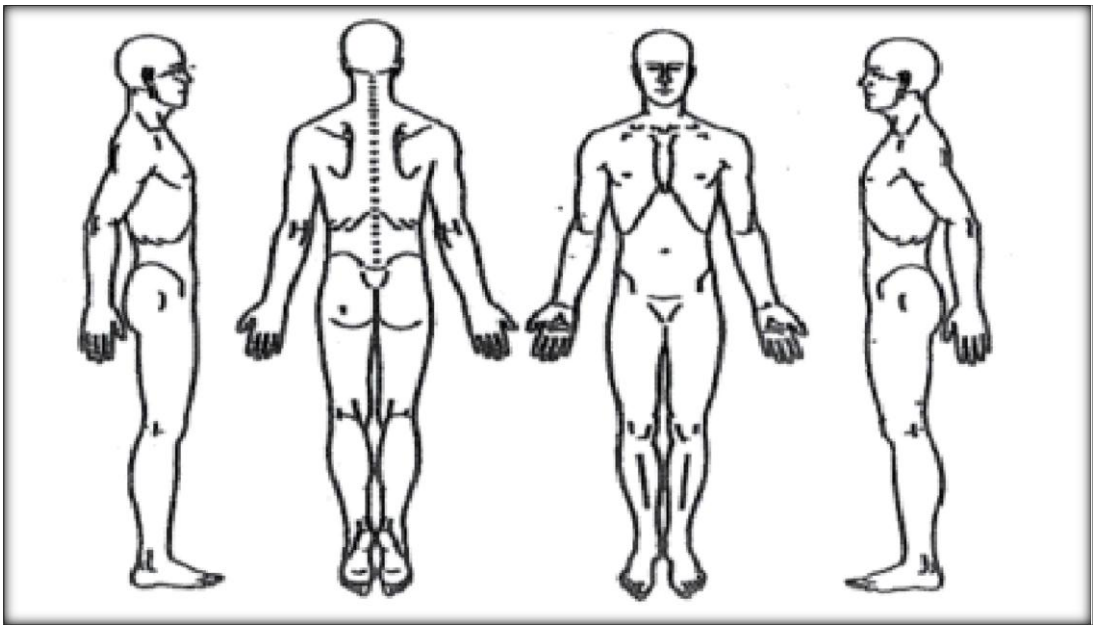
Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently?_____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? ❑ Unknown ❑ Light ❑ Medium ❑ Firm

Mark with: **O** where you feel stress or pain - **X** spots to be avoided – **T** spots that are especially ticklish

Most Stress/Pain	
STRESS & PAIN METER	10
	9
	8
	7
	6
	5
	4
	3
	2
	1
Least Stress/Pain	



Type of pain: ❑Dull Ache ❑Tingling ❑Numbness ❑Sharp ❑Stiffness ❑Weakness ❑Shooting ❑Throbbing ❑Burning

Do you exercise regularly? ❑ Yes ❑ No How often? _____

If Yes then what type of exercise? _____

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Medical Information

Are you currently under medical supervision? ❑ Yes ❑ No

Name of Physician: _____ Contact #: _____

Health Insurance Carrier _____

Were you referred by another Health care professional? ❑ Yes ❑ No

Referred by: _____ Profession:_____

Contact #: _____

Do you currently have any acute injuries that have occurred in the past 72 hours? ❑ Yes ❑ No

If yes, please explain: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Check all that apply	Past	Present		Past	Present
Allergies			Joint Injuries/Problems		
Arthritis			Kidney Disease		
Back Injuries/Problems			Liver Disease		
Blood Clots			Lung Disease		
Bruise Easily			Numbness/ Tingling		
Carpel Tunnel Syndrome			Paralysis		
Circulation Problems			Pregnant		
Contact Lens			Previous Trauma		
Cancer			Sciatica		
Digestive Problems			Seizures/Epilepsy		
Diabetes			Sinusitis		
Fibromyalgia			Skin Problems		
Headaches			Stoma/Colostomy/Ileostomy		
Heart Disease			Stroke/ CVA		
Hypertension			Surgeries		
Hypotension			TMJ (Jaw pain)		
Infectious Disease			Varicose Veins/		
Inflammatory Disease			Thrombophlebitis		

If you checked any of the following questions, please explain as clearly as possible.

Please briefly explain all checked problems/ issues: _____

_____

_____

Are you taking prescription drugs?: ❑ Yes ❑ No
Do you take blood thinning drugs? ❑ Yes ❑ No
Do you take regular analgesic drugs? (Pain killers) ❑ Yes ❑ No
Do you take regular therapeutic narcotic drugs? ❑ Yes ❑ No
Have you eaten within the past 2 hours? ❑ Yes ❑ No
Have you drunk alcohol today? ❑ Yes ❑ No

Do you have any other condition or relevant information you think the therapist should be aware of? If so please give details

_____

_____

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Informed Consent

The Texas Administrative Code, Title 25, Part 1, Chapter 140, Subchapter H, Rule §140.304 states that this initial consultation document is required and that it must include the following information:

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I understand that all massage therapy given by George James LMT, is for the basic purpose of soft tissue manipulation, stress reduction, relief from muscular tension or spasm, or for increased circulation and energy flow.

The type of massage techniques to be used: ❑ Swedish ❑ Deep Tissue ❑Trigger Point ❑Sports ❑ Other _____
For relaxation and relief of muscle pain

The massage therapist will not perform breast massage on female clients without the written consent of the client.

Draping will be used during the session and only the areas being massaged will be exposed as necessary, unless otherwise agreed to by both client and therapist.

If you (the client) are uncomfortable for any reason, the client may ask the therapist to cease the massage, and the therapist will do so. In addition, as therapist, I also reserve the right to terminate the session in the event of any sort of abusive behavior from the client. If clients behavior should result in an abbreviated session, the client will be expected to render full payment.

If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes maybe adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should seek a physician, chiropractor or other qualified medical specialist for any condition that requires treatment. I also understand that massage therapists do not perform spinal or skeletal adjustments, diagnose illness or disease, or any other physical or mental disorders, prescribe pharmaceuticals for or treat any physical imbalances, and that anything said during the session(s) should not be construed as such. If I have a medical condition or specific symptom for which massage maybe contraindicated (should not be given), a referral from my primary care provider maybe required before massage can be given. This referral maybe required as massage is not appropriate in all circumstances.

I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

In consideration for this, I do hereby discharge this therapist, all affiliates, directors, officers and employees from any and all causes of action, suits, debts, claims and any kind whatsoever arising from or by reason of any injuries which might occur as a result of having therapeutic massage performed. By signing below, I acknowledge that I have read and understand the meaning of this release.

Client Signature _____ **Date** _____

Practitioner Signature _____ **Date** _____

Consent to Treatment of Minor: **By my signature below, I hereby authorize** _____**to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.**

Signature of Parent or Guardian _____**Date** _____