CONFIDENTIAL CLIENT INFORMATION

Name _____ Date _____

Preferred Pronouns ❑ Her/She ❑ Him/He ❑ They/Them

Street _____ City _____

State _____ Zip _____ E-mail Address _____

Phone (_____)_____ ❑ Cell ❑ Can receive texts ❑ Land line

Occupation _____ Date of Birth _____ Age _____

Primary health care provider _____ Phone (_____)_____

Permission to consult with primary provider? Please initial if yes ❑ Yes_____ ❑ No

Emergency Contact: _____ Phone (_____)_____

Massage Treatment Information

Have you ever received a professional massage? ❑ Yes❑ No If yes, frequency _____Date of last massage _____

What results do you want from your massage sessions and/or primary reason(s) for which you are seeking massage treatment today?

_____

_____

List stress reduction and exercise activities, include frequency: _____

_____

List current medications including aspirin, ibuprofen, herbal remedies, supplements, etc. _____

_____

_____

Previous Health History

Surgeries, major illnesses and/or other hospitalizations - treatment and year occurred: _____

_____

_____

Injuries/accidents – treatment and year occurred: _____

_____

_____

_____

Please mark any of the following that you now have or have had in the past. Please explain. Circle applicable condition where two are listed on same line.

Now	Past	Condition	Now	Past	Condition
		General			**Respiratory and Cardiovascular**
❑	❑	Pain – Light 1 2 3 4 5 6 7 8 9 10 Severe	❑	❑	Heart disease / Irregular heart beat / Chest pain
❑	❑	Sleep disturbances/Fatigue	❑	❑	Blood clots / Thrombosis / Embolism
❑	❑	Infection / Fever	❑	❑	Stroke / Bleeding disorder
❑	❑	Inflammation / Swelling	❑	❑	Lymphedema
❑	❑	Headaches / migraines	❑	❑	High / Low blood pressure
❑	❑	Anxiety / stress / depression / PTSD	❑	❑	Poor circulation / swollen ankles
❑	❑	Allergies - Scents, oils, lotions, detergents	❑	❑	Phlebitis / varicose veins
❑	❑	Communicable illness Specify _____	❑	❑	Breathing Difficulty / Asthma / breath shortness
❑	❑	HIV /Hepatitis Exposure	❑	❑	Sinus or upper respiratory problems
❑	❑	Other _____	❑	❑	Other _____

Continued on back

Please mark any of the following that you now have or have had in the past. Please explain.
Circle applicable condition where two or more are listed on same line.

Now	Past	Condition
		Muscles and Joints
❑	❑	Broken bones
❑	❑	Rheumatoid arthritis / Osteoarthritis
❑	❑	Osteoporosis
❑	❑	Scoliosis / Spinal problems / Disc problems
❑	❑	Sprains / strains
❑	❑	Tendinitis / bursitis
❑	❑	Spasms / cramps
❑	❑	Jaw pain / TMJ disorder– right / left / both
❑	❑	Neck / shoulder / arm pain– right / left / both
❑	❑	Low back / hip / leg pain – right / left / both
❑	❑	Stiff or painful joints
❑	❑	Weak or sore muscles
❑	❑	Other _____
		Nervous System
❑	❑	Head injuries, concussions
❑	❑	Numbness / tingling
❑	❑	Dizziness, ringing in the ears
❑	❑	Loss of memory, confusion
❑	❑	Shooting / traveling nerve pain (i.e. sciatica, CTS)
❑	❑	Chronic pain
❑	❑	Other _____
		Cancer/Tumors
❑	❑	Benign, where_____
❑	❑	Malignant, where_____
		Endocrine
❑	❑	Diabetes
❑	❑	Thyroid dysfunction
❑	❑	Other _____

Now	Past	Condition
		Skin Conditions
❑	❑	Rashes / herpes / cold sores
❑	❑	Athlete's foot, warts
❑	❑	Other _____
		Digestive and Elimination
❑	❑	Constipation / Diarrhea
❑	❑	Gas / bloating
❑	❑	Irritable Bowel / Diverticulitis
❑	❑	Bladder / kidney dysfunction
❑	❑	Ulcers
❑	❑	Abdominal pain
❑	❑	Other _____
		Reproductive
❑	❑	Pregnant: Trimester? _____
❑	❑	PMS / menstrual problems / cysts / fibroids
❑	❑	Painful, emotional menses
❑	❑	Prostate
❑	❑	Erectile Dysfunction
❑	❑	Other _____
		Habits
❑	❑	Coffee, tea, soda – with or without caffeine
❑	❑	Alcohol / Drug / Tobacco
❑	❑	Other _____
		Other not identified elsewhere
❑	❑	Contact lenses (hard or soft)
❑	❑	Dentures / Bridges / Dental Implants
❑	❑	Prosthesis, where_____
❑	❑	Other _____

For Therapist Use:

Please read and initial each below to demonstrate agreement.

_____I have listed all my known medical conditions and will inform the massage therapist of any change in my physical health between sessions. I understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder, nor performs any thrusting joint adjustments or spinal manipulations.

_____If for any reason I feel my well-being is threatened or compromised or if I feel uncomfortable during the session, I agree to notify the therapist. I acknowledge I have full authority and responsibility, regardless of the reason, to determine if and when I may want the treatment paused, changed or stopped.

_____I agree to speak with my therapist each session about any concerns, considerations, limitations or exclusions, alterations/variations I may wish to be addressed/honored during that session.

_____I understand massage does not include work on genitalia. I also accept that breast, gluteal cleft or perineum massage will only be administered with explicit written and verbal permission and that a prescription/referral is required for nipple/areola massage.

_____I understand the therapist reserves the right to refuse services for reasons of safety, or should my needs exceed the therapist knowledge, skill and abilities or scope of practice.

_____I agree to give 24 hours notice if I must cancel my appointment(s).

_____I understand that I have the option to bring someone in the room as a witness/support during treatment, and it is my responsibility to provide this person for any given session.

INFORMED CONSENT

This describes how massage may impact your health and wellbeing and clarifies where you are willing to receive massage and how you would prefer to be draped during the session. Please review it carefully before signing below.

General intended outcomes for massage: Applications of massage are commonly intended to decrease pain, increase function, balance and movement, decrease tension and restrictions for not only the structures being worked directly but also for related structures (many more structures are related than most perceive). In addition, massage can reduce the adverse impact of both physical and emotional stress and facilitate a state of relaxation. When applied to maturing scar tissue it may increase pliability and function of the scar regardless if the scar is a result of injury or surgery. A balance of both specific and general focused work can positively impact the effectiveness and duration of intended outcomes

Intraoral – In the mouth massage: Specific treatment inside the mouth, may reduce headaches, tempromandibular joint (TMJ) dysfunction, ear and sinus pain/pressure and reduce neck or shoulder pain.

Chest, rib and pectoral massage: Specific treatment to the breast bone, collar bones, ribs (including underarms), as well as the upper and lower chest immediately above and below and to the sides of the breast tissue, may reduce neck and shoulder pain, improve respiration, increase flow of blood and lymph fluid throughout the body.

Breast massage: Specific treatment of breast tissues is intended to improve breast health, reduce congestion and edema, reduce pain and increase range of motion of neck, trunk and shoulders/arms, increase breast awareness, facilitate nipple health and enhance breast awareness, enhance milk flow and production for breast feeding, ease discomforts of pregnancy and breastfeeding, improve respiration. Note: for specific nipple treatment a prescription is required.

Abdominal massage: Specific treatment for the abdomen, which includes the structures below the ribs and above the pubic bone, may reduce pain in the back, legs, trunk and abdomen, improve respiration, ease restrictions or dysfunction of abdominal organs, positively impact digestion and elimination and improve posture.

Buttock, upper thigh/groin, pelvic base, tail bones (Sacrum/Coccyx), gluteal cleft, perineum massage: Specific treatment of the buttocks, upper thigh/groin, pelvis, tailbones, gluteal cleft or perineum (between anus and genitals) may reduce back, abdominal, leg and pelvic pain, numbness and tingling, and positively impact digestion, elimination or menstrual issues and may effect posture.

Please check relevant boxes below based on intended outcomes for your massage. Note this determines consent and draping restrictions.

Body Area	Consent to treat Uncovered	Consent to treat Covered through sheet	No consent is given at this time	Other consent or variation on consent	Please describe variations
Head	☐	☐	☐	☐	
Face	☐	☐	☐	☐	
In mouth (using gloves)	☐	☐	☐	☐	
Neck	☐	☐	☐	☐	
Back	☐	☐	☐	☐	
Shoulders	☐	☐	☐	☐	
Arms (including arm pit)	☐	☐	☐	☐	
Hands	☐	☐	☐	☐	
Chest (specifically not breast)	☐	☐	☐	☐	
Breast*	☐	☐	☐	☐	
*Nipples Specific nipple work is done only with Prescription					
Abdomen (ribs to pubic bone)	☐	☐	☐	☐	
Buttock, Pelvic Base	☐	☐	☐	☐	
Sacrum/Coccyx (tail bones)	☐	☐	☐	☐	
Gluteal cleft, perineum	☐	☐	☐	☐	
*Such work will be done only with Prescription					
Legs (including upper thigh and groin))	☐	☐	☐	☐	
Feet	☐	☐	☐	☐	

By signing here I grant consent for treatment as noted in the checklist above. I further acknowledge that at anytime I may withdraw or revise my consent.

Print Name _____ Signature _____ Date _____

PRIVACY PRACTICES

This notice describes how your medical information is secured, how it may be used and disclosed and how you can access this information. Please review it carefully.

The following are the confidentiality and privacy practices of Dawn M. Schmidt, LMT (hereafter known as "the clinic"),

Client Rights

Clients may request, in writing, restrictions on records - limiting the way we use or disclose their medical information for treatment, payment, or healthcare operations or limiting access to their information by someone who is involved in their care. If the request is reasonable and legal we will agree to the request and honor the restriction.

Clients may request, in writing to view or obtain a copy of their records. The client may request that corrections be made if they identify errors or mistakes. Access to records will be made during regular business hours within 30 days of receipt of written request and a fee may be charged for copying and sending requested records. Requested records are sent standard US Mail unless the client requests them to be sent via express mail (at client's expense).

A client may, at any time, revoke, in writing, permission to use or disclose medical information. If permission is revoked, medical information will no longer be used or disclosed for the reasons covered by the initial written authorization. That said, the client understands that the clinic is unable to take back any disclosures that were made with permission given prior to a written revocation and that in any event the clinic is required to retain records of the care that was provided.

Use of Records

Client records are used to document client health and treatment session information. All records when not in use are maintained in a locked file secured in the office. Client treatment records may be shared with primary care providers who are involved in patients health care.

Disclosure of Records

Client records and information is only released to anyone outside of the clinic with written authorization from the client unless compelled or required by federal, state or local laws or regulations (such as court order, subpoena, warrant, summons, discovery request, or other lawful process).

Client information may be disclosed when necessary to prevent a serious threat to client health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat from materializing.

Client medical information may be disclosed for health oversight agency activities if and only if required by law. These activities may include audits, investigations, inspections and licensure.

Client case information may be discussed with other health care providers only with written permission of the client.

At no time are client records sent electronically (e-mail or fax) unless specifically requested by the client or if compelled by law.

Changes to this Notice

The clinic reserves the right to change the terms of this notice at any time. The clinic reserves the right to apply revisions or changes to this notice effective for medical information already on file as well as any information received in the future. A copy of the current notice will be posted at the clinic office for client review. The notice will contain the effective date at the top of the the page.

Privacy Officer Contact Information

If questions or concerns arise about this notice or client privacy rights, or to file a complaint, please contact the Privacy Officer

Dawn M. Schmidt, LMT, Privacy Officer
15120 54th Pl W, Edmonds, WA 98026 fourwindsrider@frontier.com (206) 370-0538

If concerns or complaints cannot be resolved directly, clients may file a complaint with the Secretary of the Department of Health and Human Services (DHHS). There is no penalty for filing a complaint.

Receipt and Permission

I (please print)_____ have received, read and understand this policy as it relates to receiving massage from Dawn M. Schmidt, licensed massage therapist. By signing below I authorize / grant permission for the clinic to use and disclose my health information in accordance with this notice.

Signed _____ Date _____