Caroline Snijder van Wissenkerke, LMT

PATIENT INFORMATION, HEALTH HISTORY, & CONSENT

Name _____ Date _____

Email _____

Phone _____ Date of Birth___/___/_____

Address _____ City_____State_____Zip_____

Emergency Contact _____ Phone _____Relation to You_____

Health History

What is your primary goal for massage today? _____

_____

Is there a secondary goal for today's session? _____

When and how did your symptoms start? _____

_____

Prior to this onset, were you free of these symptoms? Yes_____ No _____ Explain: _____

Have you had any previous or current treatment for this issue? Yes _____ No _____

If yes, what type of treatment? _____

Do you feel your previous treatment made it: (___) Better (___) Worse (___) Same

Have you received massage / bodywork before: Yes_____ No_____ How often? _____

What form(s) or style (s)? _____

Is there any region(s) of your body you do not want massaged? _____

Are you currently receiving care from a healthcare professional (MD / ND / PT / Other)? Yes_____ No_____

If yes, please give their name and a brief explanation of the treatment. Name _____

Treatment: _____

Are you currently using any prescriptions, supplements, herbs or other medications? Yes_____ No _____

If yes, please list and explain purpose of each _____

_____

Are you pregnant? Yes_____ No_____

Any allergies (please specify)? _____

Any skin conditions? _____

What is your occupation? _____

Common Work/Leisure Activities (e.g. extended sitting, standing, lifting, bending, driving, etc.)_____

_____

How do your symptoms impact your daily functional abilities (e.g. sitting, standing, driving, sleeping, washing, house chores, athletics, caring for children, etc.)? _____

_____

Injuries, Surgeries, Major Illnesses, and Health Conditions

Less than 5 years ago _____

_____

More than 5 years ago _____

_____

_____

Other relevant health history? _____

_____

Using the diagram, please **Circle** any areas of:
Stress
Pain
Tension
Numbness/Tingling
Special Attention

Please "**X**" any areas you don't want to be touched.
(Genitals are never touched.)

Are you experiencing headaches? _____
Average # headaches per week: _____

Do you have any numbness/tingling? _____
If yes, where? _____

Consent to Treatment

I have listed all my known medical conditions, and I understand it is my responsibility to notify the massage therapist prior to treatment of any changes in my health condition as presented on this form. I give consent to treatment, and understand that modalities may include: assessments, manual therapy, suction cup therapy, self-care education, and movement awareness. I understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder, nor performs any spinal manipulations. I understand that a massage therapist does not provide medical advice nor prescribe exercise. I assume sole responsibility for anything I do based on information and opinions shared by the therapist. 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 the therapist reserves the right to refuse services for reasons of safety, or should my needs exceed the therapist's knowledge, skill and abilities, or scope of practice. I release and hold harmless Bellingham Yoga Collective, LLC and Caroline Snijder van Wissenkerke, LMT from any and all claims, demands, suits, or causes of action relating to massage therapy or movement coaching activities, for personal injury, property damage, costs, liabilities, or loss of any kind arising directly or indirectly from my participation in the aforementioned activities.

By signing here, I demonstrate my agreement to the above statements _____.

Consent for Draping Variances

My work is usually done using skin-to-skin contact. I provide draping according to professional standards, removing the drape only from the area to be addressed at the time. However, you may remain fully clothed, or I can work through the drape, if that is your wish. WA state law requires that the following areas will not be exposed during a massage: breast/chest (regardless of sex/gender), genitals, and gluteal cleft, with the exception that the breast/chest drape may be removed with prior informed verbal and signed written consent.

If you wish to give consent for your chest area to be uncovered if appropriate to the goals of the treatment, please initial here _____.
If you wish to give consent for your gluteal region to be uncovered if appropriate to the goals of treatment, please initial here _____.
Your consent may be verbally revoked at any time, for any reason.

Consent to Chest Massage

In order to achieve treatment goals, I may deem it appropriate to work on muscle or connective tissue near or underneath breast/chest tissue (for example, pectoralis or intercostal muscles). There may be incidental contact with breast tissue during this treatment. You may discontinue the treatment at any time for any reason.

Please initial your choice below:
I consent to my breasts/my chest being touched during the massage treatment for the purpose of working with surrounding or deep structures. _____

I prefer not to be touched on or near my breasts/chest. _____

Notice of Privacy Practices

In order to provide safe and effective massage therapy and bodywork, I collect personal and health information from you. You may request, in writing, to view or obtain a copy of your records. To protect your privacy, your information is never shared without your written consent, unless compelled or required by law. Client case information may be discussed with other health care providers only with written permission of the client.

If you feel that your privacy has been violated, please contact Caroline Snijder van Wissenkerke, LMT, at thrivabilitymassage@gmail.com or (206) 947-1298. If concerns or complaints cannot be resolved directly, you may file a complaint with the Secretary of the Department of Health and Human Services at HHS.gov. There is no penalty for filing a complaint.

Policies

1. Sessions include time spent filling out new patient intake forms, evaluating health history, and making a treatment plan.
2. If you are late to an appointment, you will still be charged for the full session you booked regardless of whether I have time to go over or not.
3. If I am late, we will complete the amount of time booked either that day or at a later time.
4. If you must cancel an appointment, please allow 24 hours notice to reschedule or you will be charged for that appointment (with exception for emergencies). I accept cancellations by phone only.
5. If I must cancel and reschedule an appointment due to illness or an emergency, I will call to do so as soon as possible. If it is within 24 hours of your appointment, I will provide the rescheduled session free of charge.

Do you agree to these policies? Yes _____ No_____

By signing here I grant consent for massage therapy treatment. I understand my responsibility to report changes in my health and to give feedback during treatment so the practitioner and I can work together as a team to optimize my experience.

Print Name _____ Signature _____ Date _____