Manual Therapist

HEALTH INFORMATION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Patient Information

Address _____

City _____ State ____ Zip _____

Phone: Home _____

Work _____ Cell _____

Employer _____

Work Address _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell _____

Primary Health Care Provider

Name _____

Address _____

City/State/Zip _____

Phone: _____ Fax _____

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments _____

Initials _____ Date _____

B. Current Health Information

List Health Concerns Check all that apply

Primary _____

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received _____

Secondary _____

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received _____

Additional _____

☐ mild ☐ moderate ☐ disabling

☐ constant ☐ intermittant

☐ symptoms ↑ w/activity ☐ ↓ w/activity

☐ getting worse ☐ getting better ☐ no change

treatment received _____

List Daily Activities Limited by Condition

Work _____

Home/Family _____

Sleep/Self-care _____

Social/Recreational _____

List Self-Care Routines

How do you reduce stress? _____

Pain? _____

List current medications (include pain relievers and herbal remedies) _____

Have you ever received massage therapy before? _____ Frequency? _____

What are your goals for receiving massage therapy? _____

C. Health History

List and Explain. Include dates and treatment received.

Surgeries _____

Injuries _____

Major Illnesses _____

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Check All Current and Previous Conditions Please Explain

General

current past comments

- ☐ ☐ headaches _____
- ☐ ☐ pain _____
- ☐ ☐ sleep disturbances _____
- ☐ ☐ fatigue _____
- ☐ ☐ infections _____
- ☐ ☐ fever _____
- ☐ ☐ sinus _____
- ☐ ☐ other _____

Skin Conditions

current past comments

- ☐ ☐ rashes _____
- ☐ ☐ athlete's foot, warts _____
- ☐ ☐ other _____

Muscles and Joints

current past comments

- ☐ ☐ rheumatoid arthritis _____
- ☐ ☐ osteoarthritis _____
- ☐ ☐ osteoporosis _____
- ☐ ☐ scoliosis _____
- ☐ ☐ broken bones _____
- ☐ ☐ spinal problems _____
- ☐ ☐ disk problems _____
- ☐ ☐ lupus _____
- ☐ ☐ TMJ, jaw pain _____
- ☐ ☐ spasms, cramps _____
- ☐ ☐ sprains, strains _____
- ☐ ☐ tendonitis, bursitis _____
- ☐ ☐ stiff or painful joints _____
- ☐ ☐ weak or sore muscles _____
- ☐ ☐ neck, shoulder, arm pain _____
- ☐ ☐ low back, hip, leg pain _____
- ☐ ☐ other _____

Nervous System

current past comments

- ☐ ☐ head injuries, concussions _____
- ☐ ☐ dizziness, ringing in ears _____
- ☐ ☐ loss of memory, confusion _____
- ☐ ☐ numbness, tingling _____
- ☐ ☐ sciatica, shooting pain _____
- ☐ ☐ chronic pain _____
- ☐ ☐ depression _____
- ☐ ☐ other _____

Respiratory, Cardiovascular

current past comments

- ☐ ☐ heart disease _____
- ☐ ☐ blood clots _____
- ☐ ☐ stroke _____
- ☐ ☐ lymphadema _____
- ☐ ☐ high, low blood pressure _____
- ☐ ☐ irregular heart beat _____
- ☐ ☐ poor circulation _____
- ☐ ☐ swollen ankles _____
- ☐ ☐ varicose veins _____
- ☐ ☐ chest pain, shortness of breath _____
- ☐ ☐ asthma _____

Allergies

current past comments

- ☐ ☐ scents, oils, lotions _____
- ☐ ☐ detergents _____
- ☐ ☐ other _____

Digestive/Elimination System

current past comments

- ☐ ☐ bowel problems _____
- ☐ ☐ gas, bloating _____
- ☐ ☐ bladder/kidney/prostrate _____
- ☐ ☐ abdominal pain _____
- ☐ ☐ other _____

Endocrine System

current past comments

- ☐ ☐ thyroid _____
- ☐ ☐ diabetes _____

Reproductive System

current past comments

- ☐ ☐ pregnancy _____
- ☐ ☐ painful, emotional menses _____
- ☐ ☐ fibrotic cysts _____

Cancer/Tumors

current past comments

- ☐ ☐ benign _____
- ☐ ☐ malignant _____

Habits

current past comments

- ☐ ☐ tobacco _____
- ☐ ☐ alcohol _____
- ☐ ☐ drugs _____
- ☐ ☐ coffee, soda _____

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____

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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 Seattle Sports & Therapeutic Massage, LLC (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 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

Brandi A Aubrey, LMT, Privacy Officer
10116 Main St, Suite #103 Bothell, WA 98011 (206) 470-0792

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 Seattle Sports & Therapeutic Massage, LLC. By signing below, I authorize /grant permission for the clinic to use and disclose my health information in accordance with this notice.

Signed _____ Date _____

OFFICE POLICIES

This describes the policies of our clinic. Please review it carefully before signing below.

Arrival to your Massage: New, first time clients are asked to arrive 15 min early to their first appointment. This allows time to fill out the appropriate client forms. Established clients should arrive 5 min before their scheduled time. All massage appointments have a specific time schedule, and early arrival allows for a relaxed, unhurried start to your massage. If a late arrival is inevitable, please call to let us know. (See Late Arrival section below.) Please take possible delays for traffic, weather, and parking in to account for your arrival time.

Cancellation Policy*:* Please provide a 24-hour notice if you need to reschedule or cancel your massage. This gives us enough time to fill the slot, and allows someone on our waitlist to get an appointment. If you are unable to do so, and miss your appointment, you will be considered No Call/No Show, and will be charged in full for your missed appointment.

Late Arrival*:* Due to our busy schedule, treatment sessions have a specific time allotment, therefore we regret to inform you that late arrivals will not receive extension of scheduled appointment times. If you arrive up to 10 min late, your remaining time will be accommodated as a shortened session, and you are still responsible for the cost of the entire time that was scheduled. If we have not heard from you by 15 min late, you will be considered No Call/No Show, and will be charged in full for your missed appointment.

No Call/No Show*:* Clients who do not show for an appointment without cancelling are still responsible for payment in full for the missed session. Repeated no shows could result in no longer being allowed to pre-schedule appointments, and being asked to call for same-day openings, when available.

Walk-In Appointments*:* Unfortunately, we do not accept walk-in appointments. Please call ahead to make an appointment. **Existing and new medical conditions:** It is the responsibility of the client to keep the massage therapist informed of any medical treatment and medications

Medical History Changes: It is the responsibility of the client to keep the massage therapist informed of any changes to medical care, illnesses/injuries, medications, and treatments since their prior appointment(s).

Treating Minors*:* We are trained and prepared to work with minors at our clinic. If the child is under 18 years old, we will ask a parent or guardian to be present at the first appointment. Subsequent appointments, the parent or guardian can stay at our clinic, or must be there for drop-off and pickup, and needs to be easily reachable if we need to contact you during the session.

Payment: Payment is due in full at time of service. We do not bill any insurance, including major medical plans, car accidents, and L&I. All sales, including prepay packages and gift certificates, are final. For more information about the forms of payment we accept, or for information about insurance reimbursement options, please see the Pricing Guide section in the Main Menu, or call to ask for more information.

Privacy Policy*:* Your massage therapy records are kept in the strictest confidence by this clinic. All client records are kept in a secure place, and only those who need to see a client's file for legitimate business purposes have access to them. Your records will not be released to third parties, including health care providers and insurance companies, without your written consent. Records may be surrendered if required by law.

Conduct*:* Inappropriate behavior will not be tolerated. Requests for sexualized massage, even in jest, is considered solicitation by local authorities, and will be reported as such. Suggestive comments and sexual innuendos, as well as inappropriate touching of yourself or touching the therapist during the session is not allowed. These actions will result in the immediate termination of the session, and our full fee will be expected.

Right of Refusal: In accordance with local laws, we reserve our right to refuse service at any time.

By signing here, I grant agree to abide by the policies as set forth above.

Print Name_____

Signature_____ Date_____

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. I understand the risks associated with massage therapy can include, but is not limited to, bruising, swelling, tenderness, muscle sprain/strain, and light headedness. I understand the risk, and wish to proceed with my massage care. I understand that it is my responsibility to communicate with the therapist if I feel uncomfortable in any way during the session so that they may adjust accordingly. Massage therapists are not medical doctors, and cannot prescribe, diagnose illness, disease, or mental disorder **Prior to each massage session, the treatment plan will be reviewed with you for your consent.**

General draping and permission to touch: By signing this form, I consent to receiving massage therapy at this clinic. This will include touching my back, neck, shoulders, arms, hands, legs, feet, head, scalp, and face. (I give additional consent for sensitive areas as listed below.) Draping will be used by the therapist as required to expose only those parts of my body that are being worked on at the time, in accordance with my own comfort level.

***Intraoral (in the mouth) massage:** Specific treatment inside the mouth, may reduce headaches, TMJ pain/dysfunction, ear and sinus pain/pressure and reduce neck or shoulder pain. Treatment will be done with the therapist sanitizing hands before and after, and wearing gloves throughout this part of the treatment.

I consent to intraoral work, if discussed in advance and deemed appropriate for my care: _____

(Initial Here to Consent)

***Chest, rib, subscapular 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. Breasts and nipples will remain covered for women, and this covering is optional for men during this treatment.

I consent to chest, rib, subscap, and pec work, if discussed in advance and deemed appropriate for my care: _____

(Initial Here to Consent)

***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. Breasts and nipples will remain covered for women, and this covering is optional for men. Lower extremities also remain covered from hip bones down during this treatment.

I consent to abdominal work, if discussed in advance and deemed appropriate for my care: _____

(Initial Here to Consent)

***Buttock, upper thigh/groin, pelvic base and tail bone:** Specific treatment of the buttocks, upper thigh/groin, pelvis, and sacrum may reduce back, abdominal, leg and pelvic pain, numbness and tingling, and positively impact digestion and menstrual pain, and may affect posture. These areas are worked within your comfort level, addressing the attachment points for the muscles. Genitalia will remain covered at all time, and will never be worked on.

I consent to buttock, upper thigh/groin, pelvic base, and tail bone work if, discussed in advance and deemed appropriate for my care:

_____

(Initial Here to Consent)

By signing here, I grant consent for treatment as noted above. I further acknowledge that at any time I may withdraw or revise my consent. This consent is valid until I inform my therapist that I wish to change it.

Print Name_____

Signature_____ Date_____

Covid-19 Informed Consent for Massage

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 may still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information and assist me in making informed choices. The 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.

To proceed with receiving care, I confirm and understand the following (Initial in all places provided).

Initial Below

- I have reviewed the changes to office this office's protocol, as listed on their website, including mask requirements, sanitizing measures and requirements, cleaning procedures, and more. This protocol has been reviewed with me by my massage therapist, and I have been able to ask any questions I might have for clarification. Furthermore, I agree to abide by these new standards that have been set forth for both my own safety, and for the safety of others at this facility. _____

- I understand my treatment may create circumstances, such as person to person contact in close proximity for an extended period of time, may provide a higher risk in which COVID-19 can be transmitted. _____

- I understand that I am opting for an elective treatment, and I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

- I confirm that neither I, or any members of my household, have experienced any of the symptoms of COVID-19 including the following, and have not experienced any of the symptoms in the 14 days prior to my massage appointments:
  **Fever* **Dry Cough* **Sore Throat* **Loss of Taste or Smell*
  **Shortness of Breath* **Runny Nose* **Diarrhea* **Sudden Onset of Fatigue or Weakness* _____

- I understand that activities such as travel, attending large gathering, and not social distancing, increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the last 14 days, I have not traveled outside the US, or traveled domestically via commercial airline, bus, or train, nor have I attended large gatherings, and have abided social distancing guidelines. _____

- I am informed that *Seattle Sports & Therapeutic Massage (SSTM)* implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of this virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment, and give my express permission to *SSTM* with providing care. _____

- I understand that some health conditions, including but not limited to the ones listed below, place me at higher risk for serious illness from COVID-19 infection. If I have one of these conditions, I should forgo massage therapy while COVID-19 is still present in my community, or obtain my physician's consent to receive massage therapy. Should I decide to proceed with massage therapy, I assume all risk related to illness from the COVID-19 infection.
  **Compromised Immune System *Heart Disease *History of Stroke *Diabetes *Pregnancy *COPD *Blood Disorders *Transplant Recipients *Obesity *Asthma and other Lung Conditions*
  *Cerebrovascular Diseases _____

- In the event that I develop any symptoms of COVID-19, or test positive for COVID-19 within in the 2 weeks after any massage I will contact *SSTM* immediately to inform them. I understand that SSTM may be required by law to notify local health departments. If they must do so, they will only provide the minimum information necessary for these requirements. I also understand that if a client, therapist, or staff member of this facility tests positive for COVID-19 within a time period that places me at risk of exposure, my name and contact information will be shared with the State Department of Health for their follow-up. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL INDERSTANDING 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 HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT, AND APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT IT'S CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPORPRIATE FOR MY CERCUMSTANCE. I INTEND FOR THIS CONSENT TO CIVER THE ENTIRE COURSE OF CARE FROM *SSTM* FOR MY PRESENT CONDITION, AND ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE.

Print: _____
Name of Client

Signature: _____ Date: _____