Diane M. Hovest, LMT, NCTMB, NMT
108 Dr. Thatye Drive, P.O. Box 132
Glandorf, OH 45848
(419) 538-7500

INFORMED CONSENT FOR MASSAGE THERAPY

Theraputic Massage is intended to bring about relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and enhance other forms of medical treatment.

I acknowledge that Massage Therapy is not intended to cure illness and is not a substitute for medical treatment or medication prescribed by my primary care physician. I understand there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I am aware that the massage therapist cannot diagnose illness, prescribe medications, or perform spinal or any other joint adjustments.

My insurance is an agreement between my insurance carrier and myself, therefore, I am responsible for payment of any services rendered at the time of the massage session. However, the therapist will provide information to my insurance carrier, upon request in writing from my insurance carrier, regarding my condition and procedures performed during the massage sessions indicated.

I understand a massage session may be terminated at the discretion of the therapist, on the grounds of any inappropriate conduct of the client, verbal or physical, and no refund shall be granted for such a termination.

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I have read, or had read to me, this above described consent form. I have had the opportunity to ask relative questions if I desire, concerning a massage session, and by signing this form, I agree to all above procedures with full knowledge and consent. I intend for this form to cover this massage session as well as any future massage sessions for which Diane Hovest, LMT, NCTMB, NMT is the health care provider.

LATE-NO SHOW-CANCELLATION POLICY: A 24 hour notice for cancellation or change of appointments is required. A $20.00 fee will be charged for failure to notify of change or cancellation. A client arriving late for a scheduled appointment will receive massage for the remainder of the scheduled appointment and will be responsible for full payment of that appointment.

Printed Patient Name:______________________________________ Date:____________________

Patient Signature:__________________________________ Witness:____________________________

(Parent / Guardian if patient is minor child)

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PERSONAL MEDICAL HISTORY

Patient Name:_______________

Address:_______________ Date of Birth:_______________ Age:_______

_______________ Height:_______________ Weight:_______________

Home Phone Number:_______________ Sex: M F Marital Status: S M W D

Social Security Number:_______________ Name of Spouse:_______________

Employer:_______________ Family Physicisn_______________

Occupation:_______________ Date of Last Physical Exam:_______________

Work Phone Number:_______________ Emergency Contact:_______________

Cell Phone Number:_______________ Person Responsible for payment:_______________

NOTE: Diane M. Hovest, LMT, NCTMB, NMT is committed to maintain the privacy of your health information.

CHIEF COMPLAINT:_______________

____

Rate your pain: On a scale of 0 - 10, 0 being no pain to 10 being extreme pain._______________

Have you ever received massage before? Yes_______ No_______ Frequency_______________

How did you hear about our office? _______________

ALLERGIES: (List Reactions)_______________

ASSISTIVE DEVICES: _______ Vision: _____Glasses _______Contacts

_______ Dentures: _____Upper _______Lower

_______ Hearing Aids: _____Right _______Left

CURRENT MEDICATIONS:_______________

____

Did you take your medication today? _______Yes _______No

PAST SURGERIES / HOSPITALIZATIONS / ACCIDENTS:_______________

____

RATE your degree of flexibility: _____Excellent _____Good _____Fair _____Poor

CHECK your most frequent body position: Check all that apply.

_____Standing _____Sitting _____Bending _____Leaning forward/backward

_____Lifting _____Kneeling _____Stooping _____Leaning to side: ___Right ___Left

_____Head held long hours in abnormal position _____Repetitive body movement

Specify:_______________

CHECK all conditions that apply. Please add comments to clarify the condition.

Musculo-Skeletal:

__Headaches
__Joint stiffness/swelling
__Spasms/cramps
__Broken/fractures bones
__Strains/Sprains
__Back, hip pain
__Shoulder, neck, arm hand pain
__Leg, foot pain
__Chest, ribs, abdominal pain
__Problems walking
__Jaw pain/TMJ
__Tendonitis
__Bursitis
__Arthritis
__Osteoporosis
__Scoliosis
__Bone or joint disease
__Other______________

Circulatory and Respiratory:

__Dizziness
__Shortness of breath
__Fainting
__Cold feet or hands
__Cold sweats
__Swollen ankles
__Pressure sores
__Varicose veins
__Blood clots
__Stroke
__Heart condition
__Allergies
__Sinus problems
__Asthma
__High blood pressure
__Low blood pressure
__Lymphedma
__Other____________

Skin:

__Rashes
__Allergies
__Athlete's Foot
__Warts
__Moles
__Acne
__Cosmetic Surgery
__Other:____________

Digestive:

__Nervous stomach
__Indigestion
__Constipation
__Intestinal gas/bloating
__Diarrhea
__Irritable bowel syndrome
__Diverticulitis
__Crohn's Disease
__Other______________

Nervous System:

__Numbness/tingling
__Twitching of face
__Fatigue
__Chronic pain
__Sleep disorders
__Ulcers
__Paralysis
__Herpes/shingles
__Cerebral Palsy
__Epilepsy
__Chronic Fatigue Syndrome
__Multiple Sclerosis
__Muscular Dystrophy
__Parkinson's Disease
__Spinal cord injury
__Oher:___________

Reproductive System:

__Pregnancy: __Current
__Attempting to become
__PMS
__Menopause
__Pelvic Inflammatory Disease
__Endometriosis
__Fertility Concerns

Other:

__ Loss of appetite
__Forgetfulness
__Confusion
__Depression
__Drug use____________
__Alcohol use___________
__Nicotine use__________
__Caffeine use__________
__Hearing impaired
__Visually impaired
__Burning on urination
__Bladder infection
__Eating Disorder
__Diabetes
__Fibromyalgia
__Cancer
__Infectious disease (list)
____
__Other congenital or acquired disabilities (list)____________
____
____
____

COMMENTS:____

I have stated all health conditions of which I am currently aware of. This information is true and accurate. I will inform the therapist of changes in my health status prior to any future massage sessions.

Patient Signature:____________________________ Date:__________

Client Status Report

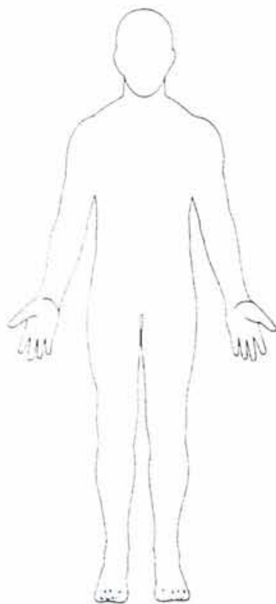
Name: ______________________________ Date: ______________

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

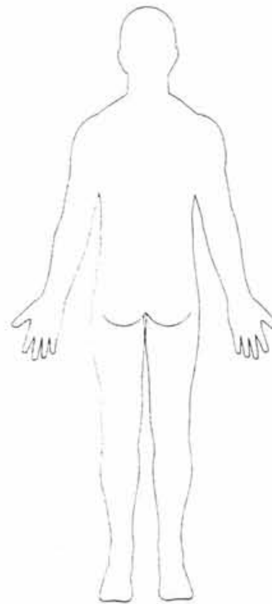
Key

- ◯ Circle areas where pain exists
- (∴) Circle areas with small dots where extreme pain exists
- ✕ Put an "X" over stiff areas
- ≋ Draw squiggly lines over areas of numbness or tingling
- ┼┼┼ Mark scars, bruises or wounds

Right



Front



Back

Left

Comments: ______________________________

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