Shannon Barrow, LMT

Relaxing Moments by Shannon

(512) 522-6299

Client Contact Information

Client Name: _____ Date of Birth: _____
Address: _____
Phone: _____ Email: _____
Emergency Contact: _____ Phone: _____
Physician/Healthcare Provider Name: _____ Phone: _____
Is this massage/bodywork medically necessary *(is it for a medical condition, injury, surgery)*? Yes ☐ No ☐

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐ How recently? _____
What kind of pressure do you prefer? Light ☐ Medium ☐ Firm ☐
What are your goals/expected outcomes for receiving massage/bodywork?

_____
How do you feel today? _____
List and prioritize any symptoms/issues you are experiencing *(e.g., stress, pain, stiffness, numbness/tingling, etc.)*:

_____
_____
List the medications you currently take:

_____
List any allergies you have:

_____

Are you pregnant? Yes ☐ No ☐ If yes, how many months? _____
Is this considered a low risk or high risk pregnancy according to your doctor/midwife? _____

Check any areas you would, or would not, like to receive massage: *(Please ask if unsure of the location name.)*
Glutes: Yes ☐ No ☐ Feet: Yes ☐ No ☐ Hands: Yes ☐ No ☐
Face/Head: Yes ☐ No ☐ Pecs: Yes ☐ No ☐
Are there any other areas you would like avoided? If so, please list:

_____

Health History

Check any conditions that you have or have had in the past.
Please answer honestly as massage may not be indicated, in whole or in part, for some conditions.

☐ Open Sores or Wounds
☐ Phlebitis
☐ Deep Vein Thrombosis/Blood Clots
☐ Joint Disorder/Rheumatoid Arthritis/Osteoarthritis/Tendonitis
☐ Osteoporosis
☐ Epilepsy
☐ Headaches/Migraines
☐ Cancer
☐ Diabetes
☐ Decreased Sensation
☐ Back/Neck Problems
☐ Fibromyalgia
☐ HIV/AIDS
☐ Carpal Tunnel Syndrome
☐ Easy Bruising
☐ Recent Accident, Injury, Fracture, or Surgery
☐ Artificial Joint
☐ Sprains/Strains
☐ Current Fever
☐ Swollen Glands
☐ Allergies/Sensitivity
☐ Heart Condition
☐ High or Low Blood Pressure
☐ Circulatory Disorder
☐ Varicose Veins
☐ Atherosclerosis

Explain in detail the conditions checked above, ***or any conditions not listed***, and the treatments received.

_____
_____

Health Information Form

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. If I feel uncomfortable for *any* reason, I may ask the therapist to cease massage and end the session.

I understand that the massage therapist may use, but is not limited to, the following massage modalities: Swedish, deep tissue, lymphatic drainage, gua sha, cupping and myofacial release.

I understand that breast massage will not be performed on female clients without the written consent of the client.

I understand that draping will be used throughout the session.

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that I am receiving massage therapy at my own risk. In the event that I become injured, either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Complaints may be made to the Texas Department of Licensing and Regulation, PO Box 12157, Austin, TX 78711, (512) 463-6599, http://tdlr.texas.gov

Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature *(for persons under 17)*: _____ Date: _____

Massage Therapist Signature: _____ Date: _____