Margo A. Spak Hemedinger, PT/LMT

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CONFIDENTIAL CLIENT INTAKE AND CONSENT FORM

PERSONAL INFORMATION

Name: ____ Today's Date: __________
Address: ____ City: ___________________
State: ___________ Zip: __________ Birth Date: ___________ Phone: _________________
E-Mail: ____
Emergency Contact: _________________________________ Relationship: ____________
Emergency Contact Phone:__________________ Reason for visit: ______________________

MEDICAL INFORMATION **Have you ever been diagnosed with any of the following:** □ None

□ Covid 19 (recent or past infection)
□ Diabetes
□ High / Low Blood Pressure
□ Heart Condition / Pacemaker
□ Congestive Heart Failure
□ Stroke (CVA) / TIA
□ Blood Clots (DVTs) / Blood Disorders
□ Circulatory Issues / Varicose Veins
□ Seizures
□ HIV+ / AIDS
□ Chemical / Alcohol Dependency
□ Fibromyalgia
□ Migraines / Headaches
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Auto Immune Disorder
□ Lupus
□ Lyme Disease
□ Asthma / COPD
□ Breathing / Sinus Issues
□ Depression
□ Anxiety
□ Chronic Pain Syndrome
□ Chronic Fatigue Syndrome
□ Hyper / Hypothyroid
□ Cancer / Where: ________
□ Lymphedema
□ Multiple Sclerosis
□ Parkinson's Disease
□ Osteoporosis
□ Scoliosis
□ Other musculoskeletal issues
□ Numbness / Tingling/↓Sensation
□ Other Medical Conditions not listed: ____

Fully vaccinated for Covid 19? □ Yes □ No If yes, what vaccine were you given:____________
If female, are you pregnant? □ Yes □ No
If over 65, you have a DNR? □ Yes □ No

Recent surgeries (last 5 years) or any medical condition you feel may be affected by massage:
____
____

Are you currently taking medication for any of the following conditions: □ None

□ Diabetes
□ High Blood Pressure
□ Migraines / Headaches
□ Seizures
□ Heart Condition
□ Congestive Heart Failure
□ Asthma/COPD/breathing Issues
□ Thyroid issues
□ Blood Thinners
□ Depression
□ Anxiety
□ Pain: Last Taken __________
□ Other Meds: ____

Are you currently experiencing any of the following symptoms / conditions?
□ Cold / Flu / Fever □ Contagious Disease □ Infection □ Swelling □ Rash □ Open Sore / Wound

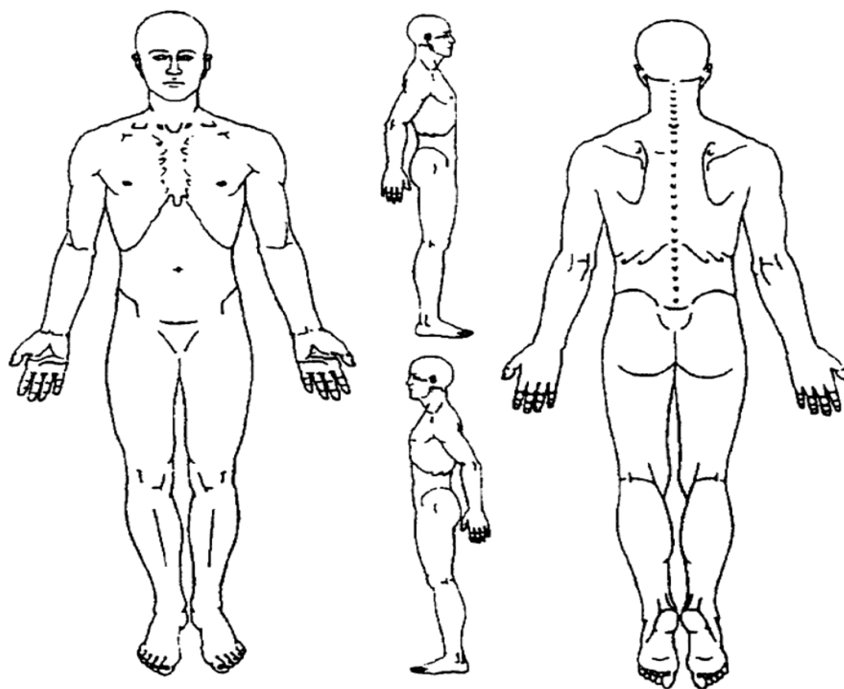
ALLERGIES / SENSITIVITIES

____
____

Massage History: □ Yes □ No If yes, how often? _____________
Pressure Preference: □ Light □ Moderate □ Deep □ I don't know

(over)

Pain **Please click on any areas of pain or discomfort or where you feel you have tension.**



Please rate your pain from 0-10
or as Min / Mod / Severe

Pain Level Now: _____

Pain at its Worst: _____

Pain at its Best: _____

Are you ever pain free? Yes
No

CONSENT FOR TREATMENT:

By signing this document, I acknowledge I have disclosed any and all medical conditions that could be affected by massage. It has been made clear to me that massage therapy is not a substitute for a medical examination, medical care or diagnosis, and that a massage therapist does not diagnose illness or disease, or any other physical or mental disorder. I have reported all medical conditions that I am aware of to this practitioner and will keep her informed of any changes in my health status. I am also aware that it is my responsibility to consult a physician when needed.

I understand that response to treatment varies on an individual basis and specific results are not guaranteed. I also understand that massage therapy and bodywork in general, are considered safe and effective methods of care however, there are some risks involved. The risks associated with massage therapy include, but are not limited to superficial bruising, short term muscle soreness, inflammation, temporary worsening of symptoms and possible exacerbation of injury and/or other conditions. I, therefore acknowledge that I was made aware of these risks prior to receiving massage therapy, and I release this LMT from all liability in the case such an injury does occur during a massage session.

I understand that by **typing or signing** my name in the signature box below, I am authorizing treatment and attest to the accuracy of the information provided. I also authorize this LMT to release or obtain any information pertaining to any of my condition(s) and/or treatment to/from my healthcare providers and/or third party payors.

Client / Responsible
Party Signature: ____ Date: _____________

LMT'S Signature: ____ Date: _____________

Consent for Treatment of a Minor or Cognitively Impaired Individual:

By my signature below, I hereby authorize Margo Ann Spak Hemedinger, PT/LMT, to administer massage therapy techniques to my child / dependent, ____________________________________, as she deems necessary.

I understand that it is the practice of this provider that all clients under the age of 18 or is cognitively impaired, must be accompanied by a parent or legal guardian throughout the entire massage session.

____ ____________________

Signature of Parent or Legal Guardian **Date**