

*Margo A. Spak Hemedinger, PT/LMT*



1249 Upper Front St / Suite 103A  
Binghamton, NY 13905  
Phone: (607) 761-9360  
Fax: (607) 217-5887  
margospak.pt.lmt@gmail.com  
www.margospak-pt-lmt.com

**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
- B Blood Clots(DVTs) Blood Disorders
- Circulatory Issues / Varicose Veins
- Seizures
- HIV+ / AIDS
- Chemical / Alcohol Dependency
- Other Medical Conditions not listed: \_\_\_\_\_
- 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

**Do you suffer from Covid Long Hauler's Syndrome?** Yes No

**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
- Other Meds: \_\_\_\_\_
- Heart Condition
- Congestive Heart Failure
- Asthma/COPD/breathing Issues
- Thyroid issues
- Blood Thinners
- Depression
- Anxiety
- Pain: Last Taken \_\_\_\_\_

**Are you currently experiencing any of the following symptoms / conditions?**

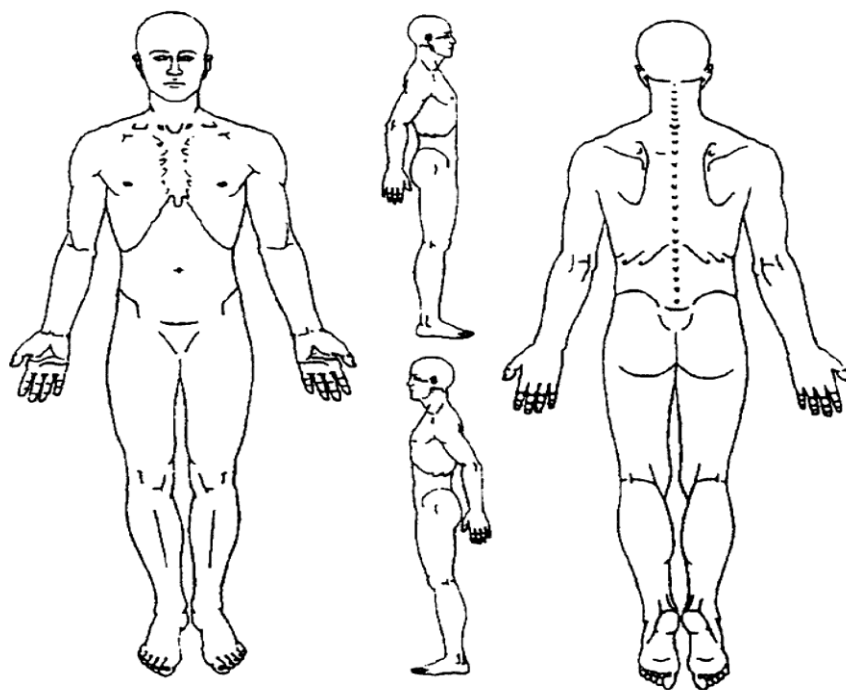
- Cold / Flu / Fever
- Contagious Disease
- Infection
- Swelling
- Rash
- Open Sore / Wound

**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**