Tricities Medical Massage

CLIENT INTAKE FORM

Personal Information

Name _____ DOB_____ Age_____

Address _____

City_____ State_____ Zip_____Cell Number _____

Occupation/Past Occupation_____Nursing Agency_____

Email address_____

Initial	Office Policies
	I agree to give at least 48 hours notice of cancellation of appointment or pay a $75 late cancellation/no show fee. Payment for late cancellations or missed appointments is patient responsibility and can not be billed to the DOL.
	I agree to inform my therapist of any changes to my health/vaccination history.
	This is a natural scent-only office. I agree that I will not wear cologne, aftershave, or perfume to my appointment. It does not wash out of the linens and you will be charged replacement cost.
	I agree to maintain healthy hygiene and shower prior to my massage appointment, especially if coming from the gym or a long work day.
	Unlike a spa massage, I understand that my therapist will ask me questions about my condition/progress and chart each visit, before, during, and after the massage and that my DOL condition is the focus of my massage treatment.

I, (name)_____ give my permission, for my therapist/practitioner to take notes about me, including health history/medical and/or personal information that I choose to disclose.

This information may be shared with my surgeon/doctor for the purpose of providing coordinated and optimal care.

I understand this information may also be used to contact me for the purpose of scheduling appointments and may be shared with employees of Michelle Rankin and Tri-Cities Medical Massage as needed for the purpose of my massage treatment plan.

In addition, Tri-Cities Medical Massage may communicate with me about my appointments via text and voicemail at the number above and via email at the address above.

Signature _____ Date _____

925 Stevens Dr Ste 3C Richland, WA 99352
risingmoonmassage@proton.me | Phone 509.947.1751 | Fax 509.984.6616

Reason For Visit

DOL SPECIFIC INFORMATION

Primary DOL diagnosis(es)_____

Describe the physical symptoms associated with your diagnosis? _____

_____

Which activities of daily living does your DOL illness limit? _____

On a scale of 1 to 10, how much pain/limitation do you experience related to your DOL diagnosis?

_____ What makes it worse? _____ What makes it better? _____

Does your DOL illness interfere with: Dressing _____ Walking _____ Work _____Sleep_____

Transferring to/from bed/toilet_____ Recreation_____ Gardening_____ Housework_____

Other ways in which your DOL diagnosis limits your daily life? _____

OTHER NON DOL PAIN/INFORMATION

Other non DOL related pain/issues we can help you with?_____

Do you experience pain when sitting? (describe)_____

Do you experience pain when standing? (describe) _____

Is this condition getting worse? Describe_____

What other treatment are you receiving for this problem? _____

Have you had massage/bodywork before?_____What type?_____

How was this experience?_____

What would you like to accomplish over the course of your treatment? _____

_____

_____

Health Information

Primary healthcare provider(s) and reason _____

_____

DOL signing doctor_____ Location _____

Current Medications & /or Supplements/Remedies _____

_____

Do you take a blood thinner?_____ Do you bleed or bruise easily?_____

Have you received a Covid vaccine? _____Which vaccine?_____Dates_____

Reaction/concerns _____

Have you tested positive for Covid? If so, please describe your illness and lingering concerns _____

_____

Allergies - specify allergen & reaction _____

Surgical History (year/type) &/or Recent Procedures_____

_____

Hospitalizations _____

_____

Accidents or Traumas _____

Falls/Injuries to Sacrum or tailbone (describe)_____

Falls/Injuries to head/back/(describe)_____

Do you have a history of abuse or trauma? _____

Do you have a history of blood clots?_____ Do you have venous insufficiency?_____

Do you use Tobacco?_____ Quantity_____ Alcohol?_____Quantity _____

Do you have osteoporosis or osteopenia?_____ Do you have arteriosclerosis (hardening of the arteries)?_____ Have you ever had a TIA, stroke, or heart attack? _____

Has anyone ever suggested you have a leg length discrepancy? _____

Have you had cancer?_____Type _____Remission?_____

Treatment received_____

Please Review and Check the Following

Please mark (X) for present and (P) for past
Bold items are really important to share with us

Circulatory

___ **Blood Clots**
___ **Unexplained or Sudden Calf Pain**
___ **Diabetes (is it controlled?____)**
___ **High Blood Pressure**
___ **Low Blood Pressure**
___ **Venous insufficiency**
___ Anemia
___ Hemophilia
___ Pacemaker
___ Raynaud's Disease
___ Varicose Veins
___ Phlebitis
___ Other Circulatory Issues _____

Nervous System

___ **Seizures**
___ **Neuropathy (hands___ feet___)**
___ **Stroke**
___ **Sciatica**
___ **Vaccine injury** (please describe)_____
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Trigeminal neuralgia
___ Neuritis
___ Restless Leg
___ ALS
___ Numbness/Tingling Where?_____
___ Other Nervous System Issues _____

Skin

___ **Fungal Infections**
___ **Warts**
___ **Athletes Foot**
___ **Skin Ulcers**
___ **Dermatitis**
___ **Psoriasis**
___ **Impetigo**
___ **MRSA**
___ Keloid Scarring
___ Large Moles
___ Other Skin Issues

Respiratory

___ Pneumonia
___ Sinusitis
___ Frequent Colds
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other Respiratory Issues

General

___ **Kidney Disease**
___ **Edema or swollen ankles**
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Bladder Infection
___ Pins and Needles feeling
___ Insomnia
___ Sleep Apnea
___ Anxiety/Panic Attacks
___ Depression

Other_____

Musculoskeletal

___ **Herniated Disks**
___ **Spine Fusion**
___ **Osteoporosis/Osteopenia**
___ **Sciatica**
___ **Thoracic Outlet Syndrome**
___ **Bursitis (where?_____)**
___ **Spasms/Cramps**
___ **Joint replacement? _____**
_____
___ Postural Deviations
___ Osteo/Rheumatoid Arth.
Where? _____

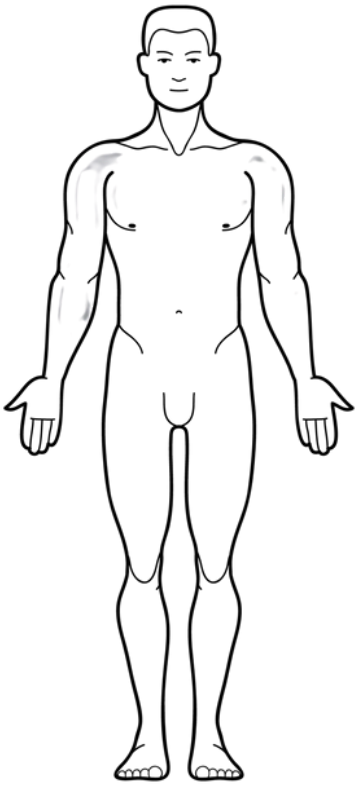
___ Cysts
___ Tendonitis
___ Torticollis
___ Disc Herniation
___ Whiplash
___ Carpal Tunnel Synd.
___ Fibromyalgia
___ Sprains/Strains
___ Ankylosing spondylitis
___ Gout

___ TMJ Disorder
___ Headache
___ Muscle Pain or Cramps
___ Leg Pain
___ Arm Pain
___ Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Neck Pain
Other_____

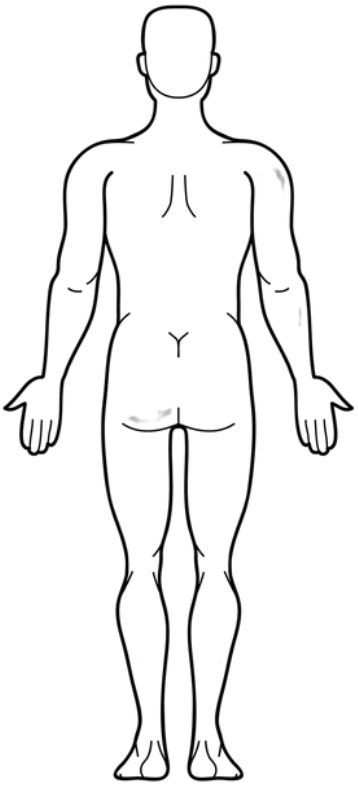
Any other health problems not mentioned above?

Please Mark Areas of Pain

Front



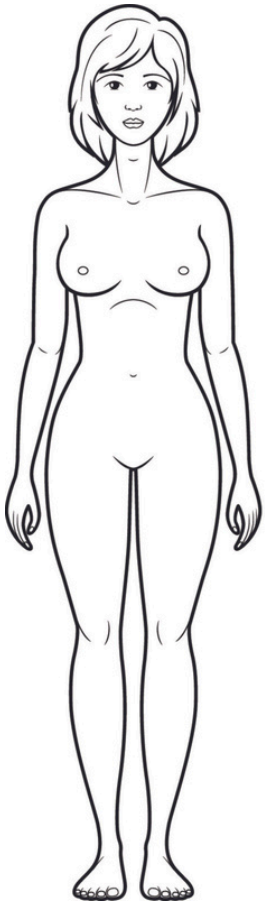
Back



Left

Right

Front



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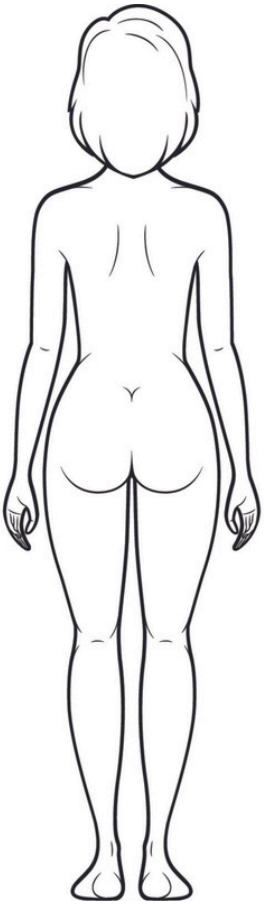

Left

Right

Liability and Assumption of Risk

I understand that Massage, Manual Lymphatic Drainage, Manual Therapy, Ashiatsu, Fascial Stretch Therapy (FST), and any other therapies received here, today and in the future, are for the purposes of stress reduction, pain reduction, relief from muscle tension, and to support healing. I have stated all of my known physical conditions, medical conditions, and medications, and I will keep my massage therapist updated on any changes.

I understand that the above therapies are not a substitute for medical care and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have. My therapist does not diagnose medical illness, disease, or any other physical or mental conditions and nothing said during the session should be construed as such. My therapist does not prescribe medical treatment of pharmaceuticals, nor does she perform any chiropractic treatments or spinal manipulations.

If at any point during the Massage and/or Manual Therapy and/or FST service I am uncomfortable or uneasy with the treatment being administered and/or if I experience pain, I understand and hereby agree that it is my responsibility to immediately inform the massage therapist, so that the massage therapist may modify massage strokes and pressure to a level of comfort and/or terminate the Massage and/or Manual Therapy Services and/or FST, if appropriate.

I voluntarily agree to assume all risks involved in receiving Massage and/or Manual Therapy/Ashiatsu/FST/ cupping/hot stones/Havening and/or any other therapies offered here. I give my consent for any Massage and/or Manual Therapy/Ashiatsu/FST/cupping/hot stones/Havening and/or any other therapies offered here, and I decide upon provided on the signature date of this document and for any future and past sessions. I have read this document and hereby freely give my permission for treatment and acknowledge and agree that I am doing so at my own risk. My health and safety with respect to any and all services/therapies offered here are my sole responsibility. I acknowledge that my receipt of any and all services/therapies offered here may result in bodily injury to me. My decision to receive Massage and/or Manual Therapy/Ashiatsu/FST/cupping/hot stones and/or any other therapies my therapist and I decide upon is voluntary, and I know, understand, and assume any and all risks associated therewith.

By signing this document and in exchange for receiving Massage and/or Manual Therapy/Ashiatsu/FST/ cupping/hot stones/Havening and/or any other therapies offered here I, for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge, and agree to hold harmless for any and all purposes, my therapist today/Michelle Rankin/Rising Moon Massage/Tri-Cities Medical Massage/Rankin Coaching, LLC, its members officers, employees, and agents from any and all liability for any and all injuries, including death, damages, claims, or demands relating to or resulting from the receipt of the Massage and/or Manual Therapy/Ashiatsu/FST/cupping/hot stones/Havening and/or any other therapies offered here, now or in the future, foreseen or unforeseen.

I further agree to indemnify and hold my therapist and Michelle Rankin/Rising Moon Massage/Tri-Cities Medical Massage/Rankin Coaching, LLC, its members, officers, agents, and employees, harmless from and against any and all claims, rights, damages, liabilities, losses, costs, and expenses (including court costs and attorney's fees) arising from or in connection with any injuries to me or other persons or damage to property caused by or attributed to me in connection with being on the premises and/or my receipt of Massage Services and/or Manual Therapy Services.

By signing below, I certify that I have read, understand, and agree to everything in this waiver.

Client Printed Name _____

Client Signature_____ Date_____

Therapist signature_____ Date_____

Please Initial	Consent for Specialized Massage Treatment
	Full Chest and Breast Massage Both men and women have breast tissue and under current regulations, must consent for massage to be performed on this region (**This consent includes bilateral mastectomy patients and those with breathing restriction for pectoral release work**). Treatment of the breast tissue is performed to increase breath health awareness, relieve congestion and edema in the upper chest and breast, ease tightness due to scar formation from surgery, east discomforts of pregnancy and breastfeeding, reduce breast and nipple pain, and increase flow of blood and lymph throughout breast tissue.
	Ribs, Diaphragm, and Pectoral Massage Treatment to the anterior thoracic cavity, including the chest and diaphragm, may be beneficial to improve respiration, improve posture, increase lymphatic and blood flow throughout the region and reduce back and neck pain.
	Intraoral Massage May help to relieve headaches, face pain, jaw pain, tinnitus, ear pain. Gloved treatment to the muscles and bony structures inside the mouth and jaw.
	Coccyx (tailbone) and Pudendal Nerve The inside portion of the ischium or "sits bones" of the pelvis houses the pudendal nerve. External treatment for the pudendal nerve and coccyx is through the sheet and may help to relieve back pain, pelvic floor issues, pain radiating down the leg, and tailbone pain.
	Abdominal Massage Treatment to the abdomen including the lower stomach below the navel and above the pubic bone may be beneficial to reduce back and abdominal pain, improve fertility, improve respiration, and increase blood flow and lymph to the abdomen and reproductive organs. Genitals remain draped and will not be massaged.
	Adductor Attachments Treatment to adductor muscle attachments at the groin and pubic bone may help to reduce pelvic pain, groin pain, hip pain, pelvic floor dysfunction, and leg pain. Genitals remain draped and will not be massaged.

I understand that I am at liberty to change my choice on any of the above during the session, have this area worked through the sheet only (except intraoral), bring a chaperone with me, or stop at any point during the treatment.

Client Printed Name _____

Client Signature _____ Date _____