The Day Spa at Goldsboro Spine Center

605 Spence Ave, Goldsboro, NC 27534
(919) 751.0555 ; Fax (919) 751.3001

Informed Consent for Massage Therapy

Overview of Benefits and Possible Side Effects:

During a massage session the therapist may use different techniques, such as relaxing Swedish massage, restorative deep tissue massage, myofacial release, lymphatic drainage, hot stone, etc. The type of massage will be discussed prior to your session.

There are some contraindications for massage (when a massage should not be given, at least on the affected area): abnormal body temperature, acute infectious disease, inflammation, osteoporosis, varicose veins, blood clots, edema, untreated high blood pressure, untreated cancer, intoxication, skin problems, hernia, and some other diseases.

Some temporary side effects of massage therapy may include (however they are usually minimal or not at all):

-Stiffness, pain, discomfort, swelling, and/or soreness
-A sensitivity or allergy to massage oils
-Headaches (especially if not drinking enough water after a massage)
-Flu like symptoms (especially after lymphatic drainage, when metabolic waste is flushed out)
-Pain or discomfort in another area of the body (sometimes by relieving the pain in the primary area, a secondary area may be getting more attention)

After the massage, it is recommended to drink more water than usual, in order to help keep the muscles and the connective tissue properly hydrated.

Appropriate draping will be used during each session. If it gets too cool or warm, you should let the therapist know and (s)he will adjust the draping and room temperature accordingly. Before the massage, the therapist will ask you to remove clothing to your level of comfort. The therapist will leave the room while you undress and remove any jewelry or other articles that might interfere with the massage. You should only take off only as much as you are comfortable removing. The massage will be most effective when the therapist can touch your skin in the areas that will be massaged. After the massage, the massage therapist will allow you to slowly get up and get dressed in privacy.

_____**Initials**

Informed Consent and Massage Policies:

I understand that the massage I will be receiving here is for the purposes of stress reduction, relief from muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that the massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

Because massage/bodywork should not performed under certain medical conditions, I affirm that I have stated all my known medical conditions, including any communicable disease; that I have disclosed all medications that I am currently taking; and that I 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 acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that is I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that she can adjust the pressure or technique being used.

I acknowledge that I am responsible to show up for my appointment on time and that the massage therapist is not under obligation to extend the therapy session. I also agree that I am responsible to pay for the full time I have booked with the therapist if I am late.

_____**Initials**

Privacy Policy

All written records and massage session are kept strictly confidential and will not be shared with any outside establishment, individuals, organization, or medical facilities without explicit written consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons or other court order.

Signature:_____ Date:_____

Consent of Treatment of Minor:

By my signature below, I hereby authorize the massage therapist to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian:_____Date:_____
Name of Parent or Guardian:_____

The Day Spa at Goldsboro Spine Center

Client Intake Form – Therapeutic Massage

Personal Information Date of Initial Visit: _____

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____ Contact Number: _____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge concerning your medical history.

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy? _____
   _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain... _____
   _____
3. Do you have allergies to oils/lotions/ointments or have sensitive skin? Yes No
   If yes, please explain… _____
   _____
5. Are you wearing… ***contact lenses*** **( )** ***dentures*** **( )** ***a hearing aid*** **( )**
6. Do you sit or stand for long hours at a workstation, computer, or car? Yes No
   If yes, please describe… _____
   _____
7. Do you perform any repetitive movements during work/sports/hobby? Yes No
   If yes, please describe _____
8. Do you experience stress in your life? Yes No
   If yes, how do you think it has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
   If yes, please identify _____
   _____
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain _____
    _____

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Are you CURRENTLY being treated or have you EVER been treated for chiropractic care?

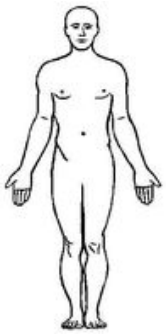
Yes No

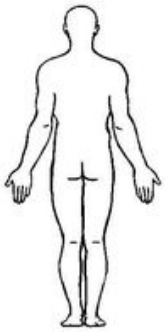
If yes, how often OR how long has it been since your last adjustment? _____

13. Circle any specific areas you would like the massage therapist to concentrate on during the session

Please indicate if you experience…

***Pain* (P)** ***Numbness* (N)** ***Tingling* (T)** ***Spasms* (S)**





14. **Please check any condition listed below that applies to you:**

( ) open sores or wounds

( ) easy bruising

( ) recent accident or injury

( ) recent fracture

( ) recent surgery

( ) artificial joint

( ) sprains/strains

( ) current fever

( ) swollen glands

( ) allergies/sensitivity

( ) heart condition/high or low blood pressure

( ) circulatory disorder/phlebitis/ atherosclerosis

( ) deep vein thrombosis/blood clots

( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis

( ) osteoporosis

( ) epilepsy

( ) headaches/migraines

( ) cancer

( ) diabetes

( ) decreased sensation

( ) back/neck problems

( ) Fibromyalgia

( ) TMJ

( ) carpal tunnel syndrome

( ) tennis elbow

( ) varicose veins

Please explain any condition that you have marked on the previous page.

_____

_____

_____

15. Are you currently taking any medications? Yes No

If yes, please list _____

_____

_____

_____

16. On a scale of 0 to 10, 0 meaning no pain and 10 meaning the worst pain you've ever experienced, what is your pain level TODAY? _____

17. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

18. How did you hear of our office?

Internet: _____ Client Referral: _____ Other: _____

NOTICE: Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, (print name) _____understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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. I further understand that massage 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 that I am aware of. I understand that massage 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 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.

Signature of client:_____Date:_____