Kethry Molly G. Boettcher, LMT, RYT

Massage Intake Form ~ **Confidential Information**

Welcome and thank you for coming in today. I would like to make your appointment as pleasant and comfortable as possible. If you have any questions regarding your session, please let me know and I'll be happy to discuss.

Name: _____ Date: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____ Gender: _____

Email: _____ Date of Birth: _____

Emergency contact name: _____ Your Occupation: _____

Emergency contact information: _____

General Questions

Have you had a therapeutic massage before? ☐ Yes ☐ No If yes, how often? _____

What are your goals for your massage today? _____

Health Information

Are you under the care of a physician? ☐ Yes ☐ No

If yes, please state what you are being treated for. _____

Are you taking any medications? ☐ Yes ☐ No

If yes, please list current medications. _____

Have you had any surgeries? ☐ Yes ☐ No

If yes, please list what for and when. _____

Have you had any injuries or accidents? ☐ Yes ☐ No

If yes, please describe. _____

Are you pregnant or trying to become so? ☐ Yes ☐ No

If you are pregnant, please identify which trimester and if there are any associated conditions. _____

In order to provide you with appropriate and client centered massage, we need an accurate health history. Please check any that apply and explain below.

☐ Skin Conditions	☐ Stroke	☐ Immune system deficiency
☐ Blood Clots (DVT, phlevitis)	☐ Diabetes	☐ Arthritis
☐ High blood pressure	☐ Cancer or tumors	☐ Osteoporosis
☐ Congestive heart failure	☐ Kidney or urinary problems	☐ Fibromyalgia
☐ Heart attack	☐ Respiratory problems	☐ Numbness or tingling
☐ Other cardiovascular disease	☐ Infectious disease	☐ Other

Explanation(s): _____

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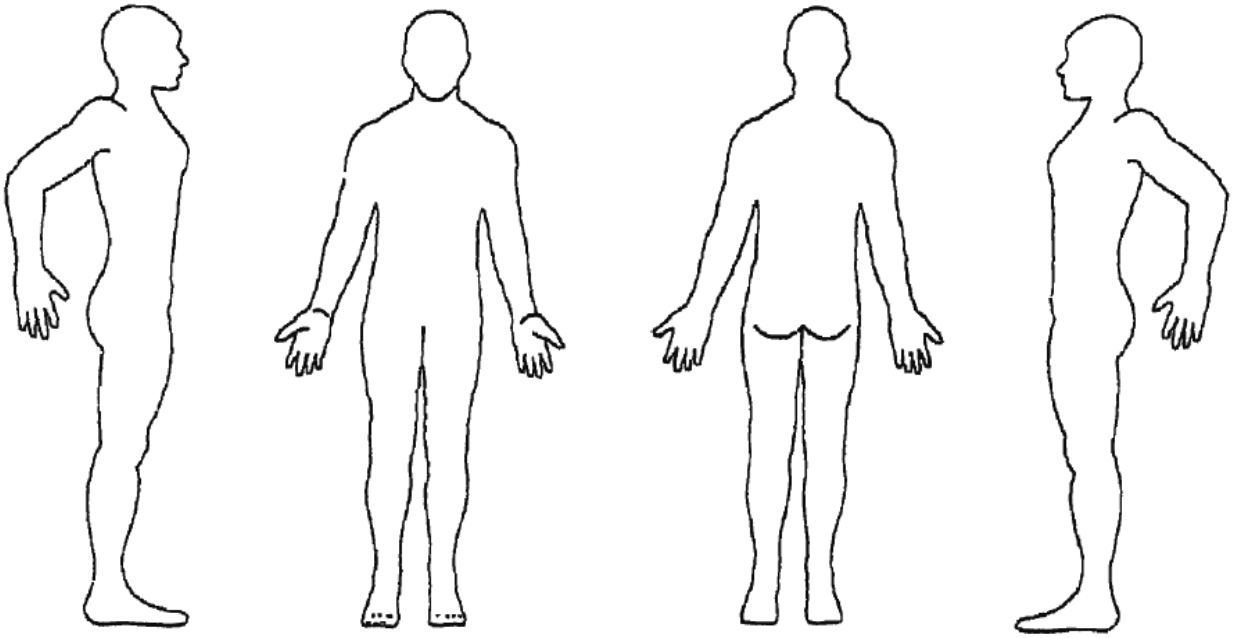
On a scale of 0 (no stress) to 10 (high levels of stress)
Please indicate the general amount of stress in your 0 _____ 10 life.

On the figures below, please indicate the following areas | Tension (T) | Discomfort/Pain (D) | Stress (S) |



I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.

I understand that massage bodywork is for the purpose of stress reduction and the relief from muscular tension, spasm, or pain. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage bodywork I hereby hold harmless and indemnify the therapist, their principals, and agents form all claims and liability whatsoever.

I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee of any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

I understand that massage bodywork is a therapeutic health aide and is non-sexual. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated.

I understand it would be harmful for me to receive a massage while under the influence of alcohol or recreational drugs and that the massage therapist has the right to refuse service and I will held responsible for cost of the session.

I understand that I am responsible for payment of my massage session on the day of service.

Signature: _____ Date: _____

Kethry Molly G. Boettcher, LMT, RYT
2011 SW Cloverdale St, Seattle WA 98106
206.499.4313 | 2011YogaMassage@gmail.com

HIPAA Privacy Statement

I give consent to **Kethry Molly G. Boettcher, LMT, RYT** to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews or research studies. Research information will be made anonymous by removing personal identifying information.

I understand that Kethry Molly G. Boettcher, LMP has the right to change privacy practices and that I may obtain any revised notices at the place of practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to any requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print name:_____

Sign:_____ Date:_____

If patient is a minor, signature of parent or guardian:

Print name:_____

Sign:_____ Date:_____