LIGHTWAY HEALING THERAPEUTIC MASSAGE

CONFIDENTIAL CLIENT HISTORY FORM

Dear Client,

Thank you for your interest in **Lightway Healing Therapeutic Massage** to assist you in your wellness needs! To better serve you, I have created a Client History Form for you to complete. Please answer each question honestly and completely! If we haven't done so already, you and I will do a brief assessment to help me get a better idea of your individual needs.
Please take your time and patiently complete this form. It's all about you! I am so grateful to serve you! God Bless!

Sincerely,

Your Massage Therapist,

Stacy Viney-Broussard ☺

CONFIDENTAL CLIENT HISTORY FORM

(Please print legibly)

NAME: _____ TODAY'S DATE: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
OCCUPATION: _____
EMAIL: _____ CELL PHONE: _____
HOME PHONE: _____ WORK PHONE: _____
REFERRED BY: _____
WHO MAY WE CALL IN CASE OF AN EMERGENCY? _____
RELATIONSHIP TO YOU? _____ PHONE: _____

YOUR AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐FEMALE

IS THIS YOUR FIRST PROFESSIONAL MASSAGE? YES or NO

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to treatment being provided.

Circle all the following that apply to you:

HIGH BLOOD PRESSURE	SEVERE LACERATIONS	PHLEBITIS	FIBROMYALGIA	INFLAMMATORY SKIN CONDITION
VARICOSE VEINS	SPASTIC PARALYSIS	ARTHRITIS	LUPUS / RA / MS	OPEN WOUNDS / OOZING BUMPS
HEMATOMAS	WHIPLASH	AIDS/HIV	LOW BACK PAIN	SUBSTANCE ABUSE
HEART PROBLEMS	FRACTURES	INSOMNIA	TMJ	NEUROPATHY
DIABETIES	STIFF NECK	HERPES	THYROID ISSUES	HEAT SENSITIVITY
DIVERTICULTIS	HEADACHES	CANCER	STROKE	EDEMA / LYMPHEDEMA
CONTAGIOUS DISEASES	SKIN DISEASE	OSTEOPOROSIS		
ALLERGIES (including latex)	EPILEPSY / SEIZURES	CARDIAC / CIRCULATORY PROBLEMS		

Other (not stated above); please explain: _____

Y N Are you taking any blood thinner medications? If yes, please list and what it is used for:
Medication: _____Use: _____

If you circled "ALLERGIES", please list the allergy and its effect on you if exposed to it. (Ex: latex, certain oils). If it is seasonal, please state.
ALLERGY: _____EFFECT: _____

☐ **YES** ☐ **NO** Are you pregnant? How far along are you? _____

☐ **YES** ☐ **NO** Do you wear contacts?

☐ **YES** ☐ **NO** Do you wear dentures?

☐ **YES** ☐ **NO** Do you bruise easily?

☐ **YES** ☐ **NO** Are you sensitive to touch or pressure in any area? Please explain: _____
_____

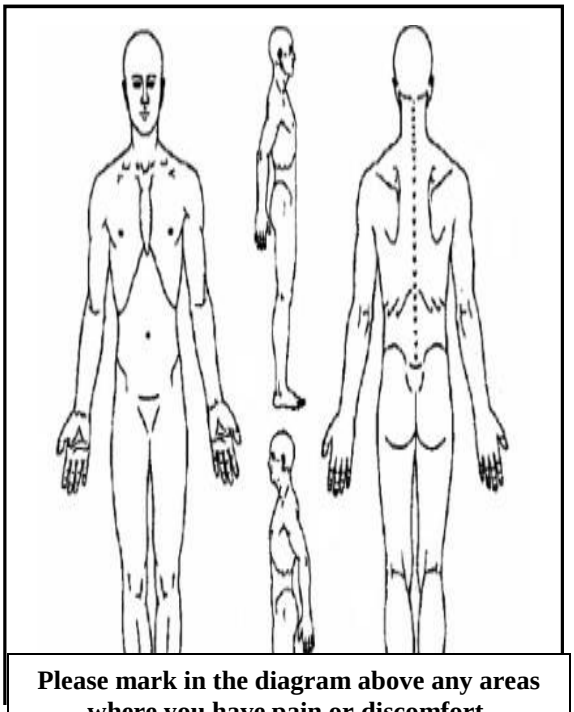
Where do you carry tension? _____

Do you suffer from joint ☐**swelling** ☐**tension** ☐**soreness**
Where? _____

In the past two years, have you had any:

☐ **injuries** ☐**broken bone** ☐**surgeries**
Please specify: _____
_____

What kind of pressure do you prefer? ☐ **light** ☐ **medium** ☐ **firm**



Please mark in the diagram above any areas where you have pain or discomfort.

Do you consent to: ☐**essential oils** ☐**hot stones** ☐**heated towels** ☐**medi-cupping** ☐**acupressure bulbs**?
**more info on these services on the Policies and Procedures document.*

□ **YES** □ **NO** *Have you ever been tested for Covid?*
If YES, date you were tested: _____

What were the results of your Covid-19 test? **POSITIVE NEGATIVE NEVER BEEN TESTED**

□ **YES** □ **NO** *Have you traveled outside of Louisiana in the past 2 weeks?*
If YES, Where? _____

□ **YES** □ **NO** *Have you been in contact with anyone with symptoms or who has been tested positive for Covid-19 in the past 2 weeks?*

□ **YES** □ **NO** *Are you caring for someone who is ill?*

□ **YES** □ **NO** *Any of the following symptoms?* **If YES, circle all that apply:**

fever, chills, cough, sore throat, diarrhea, digestion issues, shortness of breath, sudden onset of soreness, rash/skin lesions, or loss of taste/smell

□ **YES** □ **NO** *Any discomfort with exertion or exercise?*

Client Name: _____Date_____

Please initial next to each after you read:

_____ I understand that close contact with people increases the risk of infection from COVID-19. I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner (STACY VINEY-BROUSSARD). I, hereby, will not hold Lightway Healing Therapeutic Massage, nor Stacy Viney-Broussard liable if I contract Covid-19.

_____I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

_____ I further understand that massage or bodywork 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 of which I am aware.

_____ I understand that massage/bodywork practitioners 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I fail to do so.

_____ I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ I have read, received a copy of, and agree to the Policies and Procedures of Lightway Healing Therapeutic Massage, LLC., including having my credit/debit card on file and used for a small service charge for late cancellations and full service charge for same day cancellations and no shows.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____