Healing Hands Massage & Holistic Therapies **Personal Data and Health Screen Intake**

Date: _____ **CONFIDENTIAL**

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

E-Mail:_____ Do I have permission to add your email to my list? _____

Phone:(work) _____ (home) _____ (cell) _____

Date of Birth: _____/_____/_____ Marital Status Please Circle: Single Married Divorced

Occupation:_____ Employer:_____

Name of Spouse/Significant Other:_____

Preferred Appointment Day and Time: _____

Referred By: Please circle Internet Website Person:_____

In Case of Emergency: Name & Relationship:_____Phone_____

How may I contact you? ____text ___phone ___email ____mail This gives me permission to contact you per your preference.

Can I leave a voice message on your phone? YES NO With anyone?_____

1. What is your previous experience with professional massage/other bodywork? Was it good or bad?_____
_____

2. What types of massage/bodywork have you received?_____
_____

3. What results do you wish to achieve from you massage sessions?_____
_____

4. Are you currently under the care of a health care practitioner? Circle YES NO
If yes, for what condition? _____

_____

5. Please list your physicians name, address and phone number:
Name:_____

Address:_____

Phone:_____

6. Please list all medications (including aspirin) that you are currently taking and list for what condition
***Also include herbal*/nutritional supplements _____**

_____

_____

_____

- **Do you suffer with frequent headaches? YES or NO**
- **Are you a diabetic? YES or NO**
- **Do you have high blood pressure? YES or NO**
- **Do you have cardiac or circulatory problems? YES or NO**
- **Do you have high cholesterol? YES or NO**
- **Are you pregnant? YES or NO**

7. Is there any area where you would like extra time spent?:_____

8. Any area you'd like skipped? _____

9. Any area where you seem to hold a lot of tension?:_____

10. What is your major complaint or muscular condition you would want to improve?: _____

_____

11. What activities can aggravate this condition? _____

12. What activities improve your condition? _____

13. Have you used or tried any therapy products, seen a chiropractor, physical therapist, or physician for this?:

_____

14. Lifestyle

Describe your general health _____

Describe your exercise habits _____

Describe your general diet _____

Describe how well you sleep _____

How are your bowels _____

Posture assumed most of day _____

Do you wear: Please Circle: contacts dentures hearing aid hair piece other, specify _____

Do you use or consume: Tobacco _____ **Alcohol** _____
Caffeine _____ **Recreational Drugs** _____

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc)? Explain.

_____

_____

Do you have any muscle pain and/or stiffness? Explain_____

_____

Do you have any chronic, ongoing conditions that you deal with on a regular basis? Please Explain: _____

_____

Do you have any skin rashes or other skin problems right now? _____

Do you have any trouble lying on your back, front or turning over? _____

Do you have any communicable or contagious diseases?_____

15. Medical Health History

Please Explain and Give Specific Dates

Describe any injuries or accidents:

More than 10 years ago: **Less than 10 years ago:**

Describe any surgeries or hospitalizations:

More than 10 years ago: **Less than 10 years ago:**

Do you consider that you have recovered from these events? Please explain
What kind of care did you receive?

16. **Health/Medical History:**

Please check any of the columns that pertain to you. **PLEASE explain if necessary**

	YES	PAST	GIVE DETAILS
High Blood Pressure			
Low Blood Pressure			
Heart Disease/Condition/Problems			
Stroke			
High Cholesterol/Arteriosclerosis			
Epilepsy/Seizures/Convulsions			
HIV/AIDS			
Herpes I or II/Shingles/HPV			
Hepatitis A, B or C			
MRSA/Staph			
Diabetes (indicate if have insulin pump)			
Varicose Veins			
Easy Bruising			
Phlebitis/Blood Clots/PAD			
Edema/Fluid Retention			
Lymphedema			
Vertigo			
Inner Ear Problem/Dizziness			
Headaches			
Polio			
Multiple Sclerosis			
Cerebral palsy/ ALS			
Muscular dystrophy			
Parkinson's disease			
Alzheimer			
Nerve Degeneration/Nerve Conditions			
Cancer/Tumors-what type			
Infectious Disease			
Arthritis/Osteoarthritis/Rheumatoid			
Fibromyalgia			
Chronic Fatigue Syndrome			
Numbness/tingling: INDICATE WHERE			
Fatigue			
Chronic Pain			
Sleep disorders			
Paralysis			
Depression			
Mental Illness			
Forgetfulness/confusion			
Shortness of breath			
Fainting			
Cold feet or hands			
Cold Sweats			
Asthma			
Sinus Problems			
Skin Rash			
Athlete's Foot			
Abscess or open sore			
Skin Allergies/skin sensitivity: Please Specify			
Topical Allergies: Please Specify			
Allergies			
Fractures : please list			

Back Pain			
Shoulder / Arm / Neck Pain			
Hip Pain			
Leg/ Foot Pain			
TMJ/ Jaw Pain			
Sciatica			
Bone or Disc Disease			
Spinal Problems: Be Specific			
Herniated Disc/Other Disc Problems: *WHICH DISCS?*			
Osteoporosis			
Spinal Cord Injury: PLEASE GIVE DETAILS			
Joint Stiffness/Swelling: INDICATE WHERE			
Spasms/ Cramps: INDICATE WHERE			
Strains/ Sprains: INDICATE WHERE			
Tendonitis, Bursitis, etc			
Abdominal Pain			
Nervous stomach			
Loss of appetite			
Ulcer			
Indigestion/gas/bloating			
Diarrhea			
Constipation			
IBS			
Diverticulitis			
Crohn's Disease			
Colitis			
Digestive Aids			
Intra Uterine Device/ Norplant			
Menopause			
PMS/ Painful Menstruation			
Pelvic Inflammatory Disease			
Endometriosis			
Hysterectomy			
Prostate problems			
Cosmetic surgery			

List any other additional medical conditions that your therapist should be aware of that where not included above:

_____
_____
_____
_____
_____
_____
_____
_____

Therapy Notes:

HEALING HANDS MASSAGE & HOLISTIC THERAPIES **STATUS OF CURRENT CONDITIONS**

NAME: _____ DATE: _____

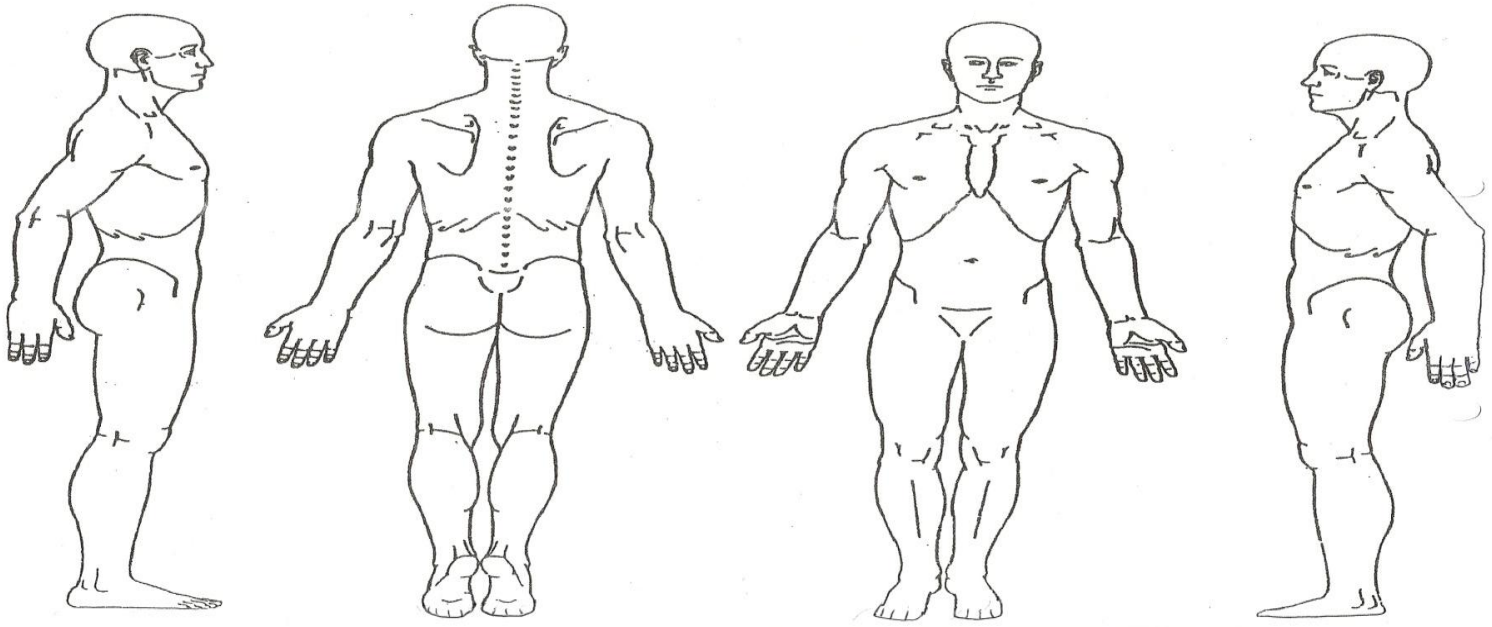
Please indicate on the diagram below areas where you currently have any symptoms.

Circle areas of pain and rank level of pain on a scale of 0 (no pain) – 10 (worst pain ever)

X Place an X on any areas of stiffness and/or numbness/tingling

↓ Use arrows to indicate the path of numbness/tingling or pain

(EX: if injury to hip, with pain going down leg to foot, draw arrow from hip down to foot)



Please describe your current symptoms. Give details such as level of pain and/or symptoms. Give description of how this has affected you, what aggravates the symptoms and what helps. Indicate any changes in medications or care due to current condition(s). Indicate any scars, rashes, skin and/or body issues.

PLEASE indicate if you suffer with cold sores or athletes foot.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Healing Hands Massage & Holistic Therapies Name:_____
Policies and Disclaimer Print Name

Please initial each policy to say that you read and understood the policy

- _____ All information you give to me will be treated confidentially. At no time will any of your information be sold to third parties. In order to maximize the effectiveness and safety of your massage session, please give feedback before, during and at the end of the each session. This will help me to better understand your needs and how to better help you in the best possible way.

- _____ 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 service being provided.

- _____ **I understand that giving 24 hours or more notice for cancellations or rescheduling will not result in any charge for that appointment**.

- _____ ***Any missed appointment without 24 hours notice* will result in a charge of the scheduled session cost**.

- _____ Punctuality will assure full use of the allotted time. I allow 15 minutes for tardiness before I mark you as a No Show. I will make a phone call to the phone number on your chart to see if you are coming and if needed to reschedule. Any missed time due to you being late will be deducted from your session time. You will still be charged the same session price. If I am running late; you will still get your full session time. If session missed, refer to charge for service above.

- _____ Missed appointment and clients running late is not only a hardship for your therapist but it's also unfair to those other clients who have an appointment after you or those on my waiting list who would have liked to have been notified of the opening.

. _____ Any returned check will result in a charge of **$25.00**; I will then only be able to accept cash or credit cards for payment.

I have read the above information and will discuss it with my practitioner. I understand that massage/movement therapies I receive are 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/movement therapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/movement 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/movement therapy 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 therapists part should I neglect to do so. I understand that massage/ movement therapies are designed to be health aids and do not constitute medical treatment. I understand that information exchanged during massage sessions is educational in nature and intended to help me become more familiar with and conscious of my own health status, and is to be used at my discretion. I take responsibility for alerting my therapists immediately if I am feeling ill. I understand that I cannot hold my practitioner liable for undisclosed conditions or irresponsible acts I might perform. It is also understood 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.

Signature: _____ **Date**_____ **Therapists int**. _____

I, _____ give Sarah Otis permission to use Therapeutic Grade Essential Oils and/or Aromatherapy on me during my therapy sessions. I have the right to refuse the use of any and all essential oils at any time if I so chose to. I will notify Ms. Otis of my wishes, I will not hold her liable for any side effects theses oils may cause or any disruption in my medications. I will immediately notify her if I am experiencing any side effects.

Signature: _____ Date_____ Therapists int. _____

Healing Hands Massage & Holistic Therapies
Sarah E. Otis, CMT, LMT, NCTMB
234 Old Airport Rd, Bristol, VA 24201
www.hhmht.com sarah@hhmht.com
423-646-9961

General Release of Information

Today's Date: _____

Client Name: _____ **Please Print**

Please initial each and sign at the bottom

_____ I give Healing Hands Massage & Holistic Therapies permission to speak or exchange any and all needed information pertaining to my current health conditions that I am seeing my regular physician for, **only if the need arises**.

ANYTHING NON-HEALTH RELATED DISCUSSED DURING INTAKES OR SESSIONS WILL NEVER BE DISCUSSED WITH YOUR PHYSICAN UNLESS YOU ARE POSING A HEALTH RISK TO YOURSELF.

_____ I give Healing Hands Massage & Holistic Therapies permission to call my physician, 911 or my Emergency Contact Person on file during an emergency situation for assistance. Only the needed information will be released for your care.

_____ I give Healing Hands Massage & Holistic Therapies permission to mail my physician a letter stating that I am receiving therapeutic massage from Sarah E. Otis, CMT, LMT, NCTMB. This allows my physician an opportunity to voice any concerns about my current health conditions and if they feel it contraindicates my receiving massage. A letter will only be sent if Sarah Otis has concerns about your current health or medical conditions and/or medications.

Physician's Name, Address and Phone Number:

_____

_____

_____

Emergency Contact Person & Relationship to you, Address and Phone Number:

_____

_____

_____

I understand that I may withdraw this consent at any time except to the extent that the authorized parties have already acted in reliance on it.

This authorization will automatically terminate in **one year** (**12**) months, at that time you will need to sign another release of information

_____ _____

Name Date

Healing Hands Massage & Holistic Therapies
Client Rights & Responsibilities /Client Information

My requirements of each client visiting my practice:

1. Sessions begin and end at scheduled times. Sessions begun late due to the client arriving late end at the appointed time and are charged the full session cost.
2. Be present (not under the influence of alcohol or drugs). Your therapist can cancel you session if you are under the influence.
3. Clients are responsible for providing, to the best of their knowledge, an accurate and complete health history and update it when necessary. You are expected to accurately disclose all medical information prior to receiving massage.
4. If cancellation is necessary, please give 24-hour notice or you will be charged your full scheduled session cost for the missed appointment unless you sent a replacement. Emergency cancellations are determined at the therapists' discretion.
5. Payment is expected at the time service is rendered. Credit Card reserve is required to hold a scheduled appointment.
6. On out-call massage appointments, if a client does not arrive within 15 minutes of the appointed time, they will be charged for the full scheduled session cost.
7. *Sexual harassment* is not tolerated at any time. If the therapist's safety feels compromised, the session will be stopped immediately.
8. *This office is a non-smoking environment.*
9. Be clean, having showered the same day as your appointment.
10. Do not eat a heavy meal less than two hours prior to the massage.
11. Clients are expected to be courteous and respect their therapist at all times.
12. Client can at any time change whom I am allowed to release information to or speak with.

What my clients can expect from their therapist:

1. I provide my clients with a competent and professional session each time they come for an appointment, addressing the clients specific needs for each session.
2. I provide my clients with a confidential setting where their privacy is always respected and maintained.
3. I am available to my clients between the hours of 10:00-6:00 Monday-Friday, 11:00-3:00 on Saturday. Clients may reach reach me at 423-646-9961 at any time and leave a voice message when I am not available.
4. I make return calls within 24-48 hours or less, unless I am out of town or otherwise stated on my voicemail.
5. Clients are treated with respect and dignity.
6. I charge a fair price for my services.
7. I do not provide direct billing for insurance.
8. Payment is due at the time of the service unless you are a Gift Certificate recipient. I accept cash, checks, VISA, MC, Discover, American Express and Debit Cards.
9. I confirm appointments the day before.
10. I perform services for which I am qualified (physically and emotionally) and able to do, and will refer you to appropriate specialists when work is not within my scope of practice and /or not in the client's best interest.
11. I keep accurate and confidential records and review them before each session.
12. I customize my sessions to meet the client's needs.
13. I stay current with information and techniques by reading massage journals, receiving regular sessions (of the same service I provide) and taking at least one workshop per year.
14. I respect all clients regardless of their age, gender, race, national origin, sexual orientation, religion, socio-economic status, body type, political affiliation, state of health or personal habits.
15. If cancellation is necessary, I will do so within 24-hours whenever possible. If an emergency arises and I can not cancel within 24-hours, I will give you a 20% discount on your next session.
16. My equipment and supplies are clean and safe and checked regularly.
17. Personal and professional boundaries are respected at all times.
18. If a client is dissatisfied with their massage session and no other arrangements or agreements could be agreed upon, a 50 % discount will be given for that day's session only.
19. Clients are draped with a sheet and blanket at all times during the session. Only the parts of the body being worked on are exposed at any time. The genitals/breasts are never exposed or massaged.

Please sign and date below that you have read and reviewed your client rights and responsibilities

Name_____ Date _____

Sarah E. Otis, CMT, LMT, NCTMB

Confidentiality Agreement

A. All information whether written, electronic or otherwise pursuant to the massage session, referral and/or contact with current physician shall be kept confidential and shall not be disclosed without specific informed written consent of the client.

B. All operations of Healing Hands Massage & Holistic Therapies shall be conducted in accordance with state and federal confidentiality rules as defined in 42 C.F.R., Part 2.

C. The only circumstances under which any client information may be disclosed without consent are:

1. To medical personnel in the event of a bona fide medical emergency
2. Under an order of a court of competent jurisdiction

D. All independent contractors whether therapists or service personnel will be required to sign an Agreement of confidentiality before conducting business pertinent to Healing Hands Massage & Holistic Therapies' operations.

This agreement shall be maintained in the personal file of every client or independent contractor and/or service personnel.

Confidentiality Statement

I understand that all information pertinent to my therapy at Healing Hands Massage & Holistic Therapies is strictly confidential at all times.

Print Name: _____

Signature: _____

Date: _____

I Sarah E. Otis, agree to maintain the confidentiality of my clients information at all times except as is required by Section C. above.

Therapist Signature: _____

Date: _____