Confidential Health Questionnaire – Ivey Massage Therapy

Client Name;_____Date of Birth _____Today's Date:_____
Street Address:_____City_____Zip_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Email Adress: _____ Occupation:_____

What is the reason for your visit today?_____
Is there anywhere you would like extra time spent, any area where you have muscle pain/stiffness/tension?
_____
Daily activities/sports/hobbies/exercise:_____
Posture assumed most of the day:_____
Known allergies (lotion/nuts. Etc.)_____
Are you currently taking: any prescription medication (Name and dosage)?_____
Any over the counter Medications (Tylenol, Advil, allergy, etc. please specify)?_____

Medical History (please indicate below any significant medical problems and such conditions that could influence the type or depth of work done in any given area)

☐ Skin condition (acne, rash, allergies, skin cancer, abscess, open sores) Other:
☐ Lymphatic condition (swollen glands, lymphoma, lymph edema) Other:
☐ Recent injury or accident (whiplash, sprain, deep bruise) Other:
☐ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis) Other:
☐ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, carpal tunnel) Other:
☐ Joint problems (osteoarthritis, rheumatoid arthritis, gout, hyper mobile joints, sacroiliac problems, disc) Other:
☐ Bone conditions (osteoporosis, previous fracture, cancer) Other:
☐ Headaches (migranes, PMS, tension, cluster) Other:
☐ Emotional difficulties (depression, anxiety, psychotic episodes) Other:
☐ Stress related disorders (stomach ulcers, PTSD) Other:
☐ Previous surgery (please state type and date)
☐ Other medical considerations
☐ Do you use any of the following (contacts, dentures, hearing aides, pacemaker)
☐ Blood condition (hemophilia, HIV, Hepatitis A, B, C, D, E) Other
☐ Diabetes ☐ Asthma ☐ Dizziness ☐ Are you pregnant? ☐ Blood Pressure (high, low)

Please list any recent injuries, surgeries, accidents, or medical treatments, include dates:
_____

Are you under medical care or supervision?:_____ For what condition:_____
Have you ever received Chiropractic Care?_____For what condition:_____

Consent for Care

It is my choice to receive Massage Therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments.I acknowledge that Massage Therapy is not a substitute for medical care, medical examinations, or diagnosis. I have stated all medical conditions that I am aware of and will inform my Massage Therapist of any changes in my health status.

Signature:_____Date:_____

Kindly give <u>at least 24 hours</u> notice if you need to change an appointment

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Addendum

Please answer Yes or No

Have you had a fever in the last 24 hours of 100°F or above? _____

Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?_____

Do you have any new discomfort with exertion or exercise? _____

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? _____

Have you or anyone in your household traveled out of state in the past 14 days? _____

Is anyone in your household immunocompromised or over age 65? _____

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the Coronavirus pandemic:

__ Fever __ Chills __ Cough __ Sore throat __ Diarrhea, digestive upset __ Nasal, sinus congestion __ Loss of sense of taste or smell __ Fatigue __ Shortness of breath __ Sudden onset of muscle soreness (not related to a specific activity) __ Rash or skin lesions (especially on the feet)

While information is still limited, the CDC indicates that the following underlying conditions place people at higher risk for severe illness from COVID-19: › People 65 years or older › Chronic lung disease › Moderate to severe asthma › Heart conditions › Compromised or suppressed immunity › Severe obesity (body mass index of 40 or higher) › Diabetes › Chronic kidney disease › Liver disease

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of infection from COVID-19.

By signing this form, I declare that the information I provided above is true and accurate to the best of my knowledge AND I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

(print name) _____ (signature) _____ (date)