New Client Application and Consent Form

Mind Body Spirit, LLC, Portland, Oregon

I, _____, understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Washington Department of Health and Oregon Board of Massage Therapists.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment, there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents of my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

24-Hour Cancellation & Late Arrival Policy

All cancellations must be done at least 24 business hours before the scheduled appointment time to avoid the cancellation fee. Monday appointments must be cancelled on Friday (24 business hours in advance). Session start and end times are firm. Please arrive on time for your scheduled appointment.

Cancellation Fee: $25

Please help keep scheduling accessible and convenient for all.
Thank you for your mindfulness.

_____ _____

Client Signature Date

Name:_____Birth Date:___/_____/_____

Address:_____

City:_____State:_____Zip:_____

Phone: (H)_____(W)_____(C)_____

Email:_____@_____.com__Occupation:_____

Do you have or have you ever had any of the following conditions / illnesses / problems? Circle "Y" for yes or "N" for no.

Heart Condition.....	**Y**	**N**	**Digestive Problems**.....	**Y**	**N**
High / Low BP (circle one).....	**Y**	**N**	**Eye, ear, nose, throat disorder**.....	**Y**	**N**
Hemophilia.....	**Y**	**N**	**Contagious or communicable disorders**.....	**Y**	**N**
Diabetes.....	**Y**	**N**	**Disability of feet, ankles, knees, hips, or back**.....	**Y**	**N**
Cancer.....	**Y**	**N**	**Pain, numbness and/or tingling in limbs**.....	**Y**	**N**
Convulsions.....	**Y**	**N**	**Chronic bodily discomfort**.....	**Y**	**N**
Thyroid Problems.....	**Y**	**N**	**Chest pain during exertion**.....	**Y**	**N**
Osteoporosis.....	**Y**	**N**	**Excessive tiredness**.....	**Y**	**N**
Arthritis.....	**Y**	**N**	**Illness or injury at the present time**.....	**Y**	**N**
Osteomyelitis.....	**Y**	**N**	**Contact Lenses**.....	**Y**	**N**
Phlebitis.....	**Y**	**N**	**Dentures / Removable Bridge / Braces**.....	**Y**	**N**
Respiratory Problems.....	**Y**	**N**	**I.U.D**.....	**Y**	**N**
Eliminatory Problems.....	**Y**	**N**	**Currently pregnant**.....	**Y**	**N**
Circulatory Problems.....	**Y**	**N**	**Other:**		

Please list any past injuries, accidents, surgeries and/or serious illnesses. Use additional space if necessary.

Dates:	Area(s) Affected:	Treatments

Are you currently under the care of other health care providers for an existing condition? Y / N

What kind of provider(s)? (MD, LMT, ND, Lac, etc.)_____ Date of last phy

What medications have you taken in the past 6 months? (Include herbal)_____

What is your previous bodywork or massage experience? _____

What physical activities do you do? _____

What does a typical day look like for you?_____

How did you find me?_____

Why do you want to receive massage and what are your expectations for the work?

I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Client Signature Date