LOTUS MASSAGE & BODY WORKS, LLC

MEDICAL, SPORTS, AND THERAPEUTIC

1062 Lenoir Rhyne Boulevard SE
Hickory, NC 28601

Personal Information

Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: (_____) _____ Second Phone: (_____) _____
Email Address: _____ DOB: _____
Emergency Contact: _____ Phone: (_____) _____

Massage/Therapy Session Experience

How did you hear about Lotus Massage & Bodyworks? _____
List allergies to any lotions, oils, scents, or foods? _____
Have you ever had a professional massage/medical session before? (Y / N)
If yes, what did you like and what did you not like about your last massage/medical session?

_____

What is your goal/concerns for today?

_____

Are you *uncomfortable* with any areas being massaged or touched? (Y / N) example:
Feet,Face,Scalp_____

Referral/Prescription/Billing

Do you have a referral/prescription from a Doctor? (Y / N) If so what is their name?

_____

Are you intending to bill any portion of today's treatment to insurance/workers comp?_____

Health History

List your occupation_____
Do you experience pain at work? (Y / N)
Do you experience pain while walking or in movement? (Y / N)
Do you experience pain while at rest? (Y / N)
Are you pregnant? (Y / N / Unsure / Trying) If so how far along are you? _____
Do you have any recent X-Rays or MRIs? (Y / N) If so we may ask for a copy.
Do you have any medical accessories that we need to know about? Pumps, ports, screws, rods, pacemakers, ect? (Y / N) If so, please describe the accessory/accessories and location on the body.

_____

Please list any medications/supplements that you are taking: (just major medications will be fine to list)

_____

_____

How did the pain that you're experiencing happen?

_____

_____

Did you feel pain immediately? (Y / N)

Were you admitted to the hospital for your condition(s)? (Y / N)
Since your injury, are your symptoms:
Getting Worse _____ Improving _____ Staying the Same _____
*On a scale from 1-10 (10 being the worse) what is your current pain level? 1 2 3 4 5 6 7 8 9 10

What makes your condition worse?

_____

_____

Are you seeing a Physical Therapist, Chiropractor, or Doctor for an ongoing issue? (Y / N) If so what for?

_____

Please list any surgeries:

_____

Please list any major accidents/injuries in the last few years: (car accidents/falls/sports injuries/ect…)

_____

_____

Is this case related to Work Injury? (Y / N)
If so, was the incident notified to the employer? (Y / N)
Is this case related to Auto Injury? (Y / N)
If so, were you the Driver/Passanger/Pedestrian/Other_____
Were you struck from Behind/Front/Right Side/Left Side/Other_____

Do you suffer from PTSD (Post Traumatic Stress Disorder)? (Y / N) if so, please give us a brief description.

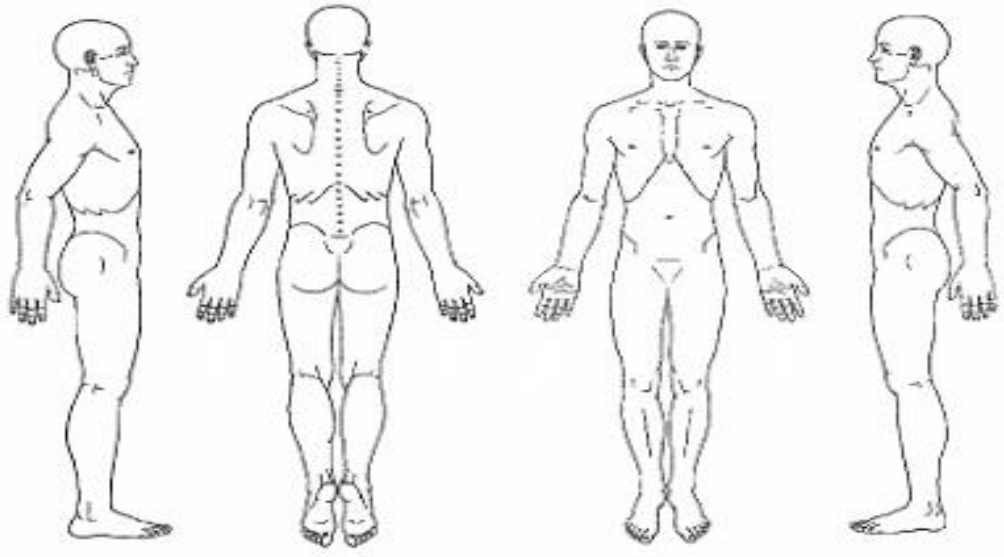
_____

_____

Do you do any of the following? Smoke? (Y / N) Drink Alcohol? (Y / N) Caffeine? (Y / N)
Are you on Blood Thinners? (Y / N)
Do you sleep on your: Right Side/ Left Side/Back/ Stomach (head turned left)/Stomach (head turned right)
Other?_____

Please identify the areas you are concerned about with X's on the chart below:

(Right View) **(L)** **(R)** **(R)** **(L)** **(Left View)**



Notes:

Health History

Do you have or have you had any of the following?

Musculo-Skeletal

__ Headaches/Migraines
__ Joint stiffness/swelling
__ Spasms/cramps
__ Broken/Fractured bones
__ Strains/Sprains
__ Carpal Tunnel
__ Sciatica
__ Scoliosis
__ Osteoporosis/Osteopenia
__ Arthritis-Rheumatoid
__ Whiplash
__ Problems walking
__ Jaw pain/TMJ
__ Tendonitis
__ Bursitis

Circulator/Respiratory

__ Dizziness
__ DVT-Deep Vein Thrombosis
__ Lymphedema
__ High/Low cholesterol
__ Gout
__ Varicose Veins
__ Shortness of breath
__ Embolism
__ Phlebitis
__ Blood Clotting issues
__ Hemophilia
__ **Bruise Easily**
__ High/Low blood pressure
__ Fainting
__ **Stroke**
__ Heart condition
__ Allergies
__ Asthma
__ Kidney/Liver Disease
__**Heart Attack**

Digestive

__ Indigestion
__ Constipation
__ Intestinal gas/bloating
__ Diarrhea
__ Irritable bowel syndrome
__ Crohn's Disease
__ Colitis
__ Diverticulitis

Nervous System

__ Lupus
__ Fibromyalgia
__ Chronic Fatigue Syndrome
__ Numbness/tingling
__ Fatigue
__ Sleep disorders
__ Ulcers
__ Paralysis
__ Herpes/shingles
__ Cerebral Palsy
__ Epilepsy/Seizures
__ Chronic Fatigue Syndrome
__ Parkinson's Disease
__ Multiple Sclerosis
__ Muscular Dystrophy

Skin

__ Rashes
__ Psoriasis
__ Athlete's foot
__ Acne
__ Impetigo
__ Open Wound
__ Eczema
__ Herpes
__ Varicose Veins
__ Shingles

Other

__ Difficulty concentrating
__ Tuberculosis
__ Sleep disorder
__ Diabetes-injection site?
__ Fibromyalgia
__ Post/Polio Syndrome
__ Depression
__ **Cancer**
__ Fever
__ Mononucleosis
__ Sudden weight gain/loss
__ Thyroidism
__ HIV/AIDS

Confidentiality

This document, all discussions between client and therapist, all sessions and therapist's documentation of treatments are considered by therapist to be highly confidential. All written materials will be kept locked and only accessible by the therapist. The therapist will only confer with the client's physician or any other

medical or insurance personnel with the prior written agreement of the client. The therapist reserves the right to refuse to treat any individual if the therapist believes a doctor's consent is necessary and the client is unwilling or unable to provide a doctor's consent.

Massage Therapy/Manual Therapy/Medical Massage
Client Waiver Form

Please take a moment to read and initial all the following statements:

By signing this, I agree that I have answered all these questions to the best of my knowledge. I will inform the therapist of any changes in my condition or medication at the beginning of each session. I understand there is no liability on the therapist's part if I have failed to notify them of any change in my medical condition while under treatment of massage/manual therapy/medical massage. _____

If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist/practitioner immediately. I will not hold my therapist responsible for any pain, bruising, or discomfort that I may experience during or after the session _____

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. _____

I affirm that I have notified my therapist/practitioner of all known medical conditions and injuries past and present. _____

I understand that there is no guarantee with any of the services that I receive. _____

I understand that massage/manual therapy/medical massage is entirely therapeutic and in a non-sexual nature. I understand that my therapist/practitioner has the right to end a session due to inappropriate conduct_____

By signing this release, I hereby waive and release my therapist from all liability, past, present, and future relating to massage therapy/manual therapy/medical massage and bodywork. _____

I understand that if I should cancel an appointment in less than 24 hours before the scheduled time or be marked as a "no show"; that I am subject to a fee equal to the cost of the missed appointment. _____

*Information and Suggestions *
*Prior to your session please remove all jewelry.
*Pull long hair back with a clip or band.
* In general, a therapeutic massage is given while you are unclothed and under a sheet. (However, you may choose to wear your undergarments or a swimsuit.)

* Manual Therapy or Medical Massage is typically performed while clothes are kept on.
• Feel free to ask your therapist/practitioner about any questions that you may have before, during, or after the session. Your therapist/practitioner is a highly trained professional and will be happy to make you feel informed and as comfortable as possible.
(Please Drink Water Before and After All Sessions to Stay Hydrated)

Client Name:_____

Client Signature _____

Underage Parental/Guardian Client Consent (Under 18 years of age)_____

Date:_____

Therapist Signature:_____