seven generations massage & birth

Pelvic Wellness & Fertility ▪ Pre and Peri Natal, Postpartum & Infant Massage ▪ Therapeutic Medical Massage

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Confidential Client Information & Informed Consent

Personal Contact Information:

Name: _____ e-mail address:_____ e-list? (Y/N)_____

Address: _____ City/State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation:_____ Employer/Industry: _____Date of Birth: ____/____/____

How did you find out about this practice?

___ Referred by friend/family. Who? _____

___ Referred by healthcare provider (ie. Physician, Chiropractor, Acupuncturist, PT, other) Who?_____

___ On-line search engine (i.e.: Google)

___Other. Kindly specify: _____

Personal Health History: Indicate with an "X" if you have or have ever had any of the following conditions/illnesses/problems?

____ Heart Condition	____ Convulsions	____ Digestive Problems
____ High/Low Blood Pressure	____ Muscle/Joint Pain	____ Skin Problems
____ Phlebitis	____ Osteoporosis	____ Respiratory Problems
____ Hemophilia	____ Arthritis	____ Infectious Diseases
____ Diabetes	____ Headaches	____ Other, please specify:
____ Cancer	____ Circulatory Problems	_____
		_____

If you know or suspect you are pregnant, how many weeks along are you? Is this your first pregnancy?

_____

_____

_____

Are you currently under the care of a physician, chiropractor or therapist?_____

If YES, for what? _____

If NO, list date of last physical _____

List current medications (including those delivered by patch) and/or herbal supplements and purpose:

_____

_____

Describe and date ALL past surgeries, accidents:_____

_____

_____

List any chronic body discomforts:_____

_____

_____

Previous professional massage/bodywork therapies received: _____

_____

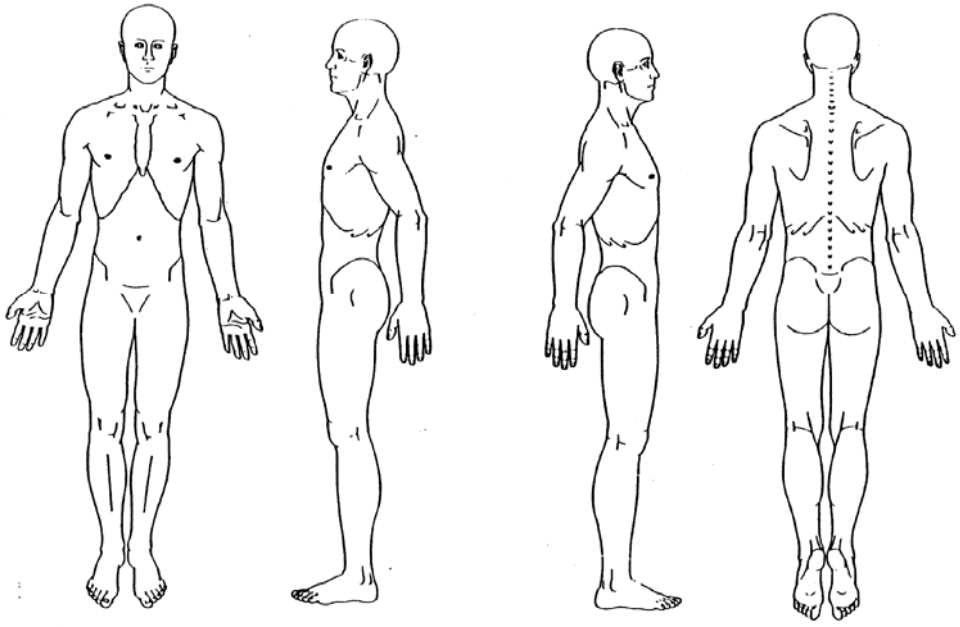
_____

Reason for scheduling your massage session today: _____

_____

_____

If you are experiencing discomfort, draw on the figures below to indicate where you are feeling it on your body.



My Informed Consent. ***I*** _____ *(client)* ***understand and agree that:*** *(please initial)*

_____ The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me by my massage therapist.

_____ My massage therapist does not diagnose illness, disease, or any other medical, physical or mental disorder, nor perform spinal manipulations.

_____ Massage therapy is not a substitute for medical treatment, and I am responsible for consulting a qualified physician for any physical ailments that I may have.

_____ It is necessary that my massage therapist be aware of any existing physical conditions that I have. I have listed all my known medical conditions, medications and physical limitations. I will update my massage therapist on any changes.

_____My therapist reserves the right to decline, discontinue, or restrict services based on any information I have provided in this form or during a follow-on session intake interview that may indicate that massage therapy would put my health or my therapist's health at risk.

_____ Any and all information collected during massage therapy sessions remains confidential and shall not be released without my written consent.

_____ It is only fair to me and to my therapist that I speak up at any time during my session if I have concerns or questions.

_____ All therapeutic massage is non-sexual. I understand that sexual activity is prohibited within the therapist-client relationship regardless of who initiates such activity. Should the therapist or client make advances or have sexual intentions relating to the massage, both parties have the right and the responsibility to terminate the session.

_____All services rendered to me are charged directly to me and I am responsible for payment unless prior arrangements have been made. If I need to cancel or reschedule my appointment I will give my therapist 24 hour notice. I agree to pay the full value of the session price should I cancel without notice. I understand that cancellations within an hour of the session may be subject to partial payment.

The information provided on this confidential intake form is correct to the best of my ability. I have read, understand and will uphold all policies.

Signature _____ Date _____