



Important, please read: Your health history is highly confidential. The information you provide will be kept confidential and will ensure that I provide you with a safe and effective treatment. Please take your time completing this form.

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (eve) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_

Referred To By \_\_\_\_\_ Is this your First Massage? Yes or No

When/where was your last massage? \_\_\_\_\_

Do you understand that we provide only professional therapeutic massage? Yes or No

List Allergies, including food: \_\_\_\_\_

List Surgeries: \_\_\_\_\_

Accidents/Injuries, including Car, Sprains, Tendonitis, etc: \_\_\_\_\_

Family History of Heart Disease and/or Diabetes? Explain: \_\_\_\_\_

Closed-Head Injury or Seizure? Explain: \_\_\_\_\_

**Please mark the following conditions that apply now with "X", and past conditions with "P"**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> headaches/migraines    | <input type="checkbox"/> chronic pain          | <input type="checkbox"/> fatigue            |
| <input type="checkbox"/> vision problems        | <input type="checkbox"/> muscle/joint pain     | <input type="checkbox"/> tension, stress    |
| <input type="checkbox"/> hearing problems       | <input type="checkbox"/> muscle/bone injury    | <input type="checkbox"/> depression         |
| <input type="checkbox"/> injury to face or head | <input type="checkbox"/> numbness/tingling     | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> sinus problems         | <input type="checkbox"/> sprains/strains       | <input type="checkbox"/> allergies          |
| <input type="checkbox"/> dental bridges         | <input type="checkbox"/> arthritis/tendonitis  | <input type="checkbox"/> rashes             |
| <input type="checkbox"/> TMJ/Jaw pain           | <input type="checkbox"/> cancer/tumors         | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> constipation/diarrhea  | <input type="checkbox"/> blood clots           | <input type="checkbox"/> varicose veins     |
| <input type="checkbox"/> hernia                 | <input type="checkbox"/> diabetes              | <input type="checkbox"/> pregnancy          |
| <input type="checkbox"/> asthma                 | <input type="checkbox"/> heart problems        | <input type="checkbox"/> high/low BP        |
| <input type="checkbox"/> digestive problems     | <input type="checkbox"/> spinal cord disorders | <input type="checkbox"/> lung conditions    |

Please explain any issues listed above in greater detail, if necessary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



What brings you in today? Explain what area(s) of your body is bothering you: \_\_\_\_\_

\_\_\_\_\_

Have you ever practiced yoga, pilates, or meditation? \_\_\_\_\_

\_\_\_\_\_

List your exercise, sport and/or hobby: \_\_\_\_\_

\_\_\_\_\_

**Our Therapeutic Agreement:**

I understand that massage therapy is strictly a professional therapy and in general provides benefits of stress reduction; relief from muscular tension, spasm or pain and it increases circulation. I understand that massage therapists and bodyworkers do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage and bodywork is not a substitute for medical examination or diagnosis, and it is recommended that I see a health care provider for those services. I accept that massage promises no long-term cures nor will it alleviate my health problems. I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status. I understand that Thrive reserves the right to deny service to a client that may be under the influence of drugs and/or alcohol.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Cancellation Policy Agreement:**

Remembering your appointment is your responsibility. If you must reschedule or cancel, please cancel within 24 hours of your appointment to avoid paying the full session cancel fee. Exceptions can be made only in emergency situations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Newsletter Permission**

By signing below, you give Thrive Massage permission to email you occasionally from MailChimp with special monthly promotions, discounts and updates.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## COVID-19: CONSENT FOR MASSAGE THERAPY SERVICES

Client First and Last Name: \_\_\_\_\_

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. Please type your initials: \_\_\_\_\_

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Please type your initials: \_\_\_\_\_

I understand that preventive measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented at Thrive Massage Ann Arbor. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to the staff at Thrive Massage & Bodywork to proceed with providing care. Please type your initials: \_\_\_\_\_

Contact Tracing Consent: 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 Thrive Massage & Bodywork 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. Please type your initials: \_\_\_\_\_

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS AT THRIVE MASSAGE & BODYWORK FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

PLEASE TYPE YOUR FULL NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

IF YOU ARE A MINOR, PLEASE TYPE FULL GUARDIAN NAME: \_\_\_\_\_  
DATE: \_\_\_\_\_