movementbodywork
form, strength, movement, foundation, structure

Samuel Hobbs LMT #20584
samuel@movementbodywork.com
503.860.5893

Client Health Information & Consent Form

** All information is held confidential **

General Information:

Date: _____

Name: _____ Gender: _____

Date of Birth: _____ Occupation: _____ Pronouns: _____

Phone (Main): _____ Ext: _____ Type: ☐ Call ☐ Text ☐ Voice Mail

Phone (Other): _____ Ext: _____ Type: ☐ Call ☐ Text ☐ Voice Mail

Email: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Emergency Contact(s):

Name: _____ Phone: _____ Ext: _____

Name: _____ Phone: _____ Ext: _____

Treatment Goals:

_____

Current Health Concerns:

Recent Injuries: _____

Long-term injuries/illnesses: _____

Surgeries: _____

Pain: _____

Numbness/loss of sensation: _____

Allergies: _____

Swelling/Inflammation/Edema: _____

Other Conditions: _____

If you have been diagnosed with cancer, please indicate type, stage, location, and if/how often you're receiving chemotherapy.

_____

_____

Please list medications or substances, and their side-effects, you are currently taking as they may affect the work performed.
(e.g. homeopathic remedies, drugs, prescribed medications, herbs, vitamins, etc.)

_____

_____

Physician(s) & Treatment Team:

Provider(s) (name, phone, reason): _____

_____

☐ I give permission to discuss, and share my health care treatment and chart notes with my health/wellness providers listed. (optional)

☐ I give permission for my chart notes and other health information to be shared as needed for my authorized insurance claims. (optional)

** Note: insurance companies require this information to process claims and disperse payments. **

Massage & Bodywork History:

Other bodywork you are currently receiving, goals, type(s), and how often? (e.g. massage, chiropractic, acupuncture, etc.)

_____

_____

Medical History:

Please indicate if you have the following organs:

☐ Uterus Ovaries: ☐ Left ☐ Right ☐ Prostate Testes: ☐ Left ☐ Right Kidneys: ☐ Left ☐ Right

☐ Appendix ☐ Gallbladder ☐ Spleen ☐ Tonsils ☐ Thyroid

Please indicate if you have any surgical implants:

☐ IUD ☐ Abdominal Mesh ☐ Gastric Band ☐ Heart Stent ☐ Pacemaker ☐ Insulin Pump

☐ Other: _____

Please indicate if you are experiencing, or have experienced, issues with any of the following systems/conditions.

** Some conditions may require a note from a medical doctor stating that receiving manual therapy is safe for you. **

☐ Urogenital (e.g. UTI's, STD's, Pregnancy, Endometriosis, Prostatitis, Painful Intercourse, Difficulty Conceiving, Libido): _____

_____

☐ Digestive (e.g. Crohn's, IBS, Constipation): _____

☐ Respiratory (e.g. Asthma, Pneumonia): _____

☐ Neurological (e.g. MS, Parkinson's, Seizures, Numbness, Tingling): _____

☐ Dizziness, Headaches/Migraines: _____

_____

☐ Spine/Disk (e.g. Whiplash, Degeneration): _____

☐ Skeletal/Joints (e.g. Osteoporosis, Breaks/Fractures): _____

_____

☐ Endocrine (e.g. Thyroid, Hormones, Diabetes): _____

☐ Circulatory/Cardiovascular (e.g. Clots, High/Low BP, Varicose): _____

☐ Integumentary (e.g. Warts, Rashes, Sores): _____

☐ Muscle/Tendon (e.g. Tension, Strains, Sprains, Hernia): _____

☐ Dental (e.g. TMJ, Jaw Tension, Grinding): _____

☐ Auditory (e.g. Hearing Loss, Ringing): _____

☐ Psychological (e.g. Depression, Alzheimer's, Memory Loss): _____

☐ Immune (e.g. HIV, AIDS): _____

☐ Cancer: _____

_____

☐ Allergies: _____

☐ Other: _____

_____

Please answer the following:

☐ I am currently pregnant or think I may be. How far along? _____

☐ I have recently given birth; and I have experienced my first menstral cycle since: ☐ Yes ☐ No

☐ I have had a miscarriage, or an abortion. Please elaborate: _____

I have experienced my first menstral cycle since: ☐ Yes ☐ No

☐ I am currently undergoing chemotherapy. Please elaborate (e.g. Treatment dates, Diagnoses, Surgeries, etc...): _____

_____

_____

Comments: _____

_____

_____

movementbodywork
form, strength, movement, foundation, structure

Samuel Hobbs LMT #20584
samuel@movementbodywork.com
503.860.5893

New Client Letter & Informed Consent

** Please read thoroughly and initial where indicated **

_____ I, the client, understand that I will be receiving manual therapy within the scope and practice of a Licensed Massage Therapist (LMT). I understand that a LMT may not perform the following outside of their scope or training: chiropractic adjustments; medical diagnoses; prescribe medications; or offer medical advice. I understand that manual therapy does not replace qualified medical advice, examination and/or treatment, and that treatment, conversations, and information provided by Movement Bodywork, and associated practitioner(s) shall not be construed as such.

_____ Regarding manual therapy, I understand the following:

- 'Organs' refer to: internal organs, blood vessels, nerves, muscles, fascia, and other tissues within the body.
- The function of my organs are a direct reflection of their ability move freely within my body. Symptoms I experience may relate across my body via lines of tension and fascial interconnections. Everything is connected.
- There is a connection between my brain (my Central Nervous System) and the function of my organs.
- 36-72 hours is the general time frame that is needed for my central nervous system to integrate new information provided to my organs via manual therapy sessions.
- The possible outcomes after a session wherein symptoms can become worse for a few days before they improve is only a reflection of my body integrating new information from a session.
- Rescheduling follow up sessions will respect the time it takes for my body to integrate a new pattern of "normal," and are scheduled for typically 3-4 weeks between sessions.
- How "successful" I perceive a session to be is not a reflection of how (un)healthy my body may be, nor how effective a session had been.
- Manual therapy is a process. My personal history and current lifestyle choices directly affect the outcomes from any given session, both expected and experienced. As an analogy:

  The history of a dysfunction is like the snow powder on a mountain, and each session is a push on a snowball from its top. How quickly, how far, and how well the snowball rolls depends on how deep the powder is—how integrated a dysfunction may be.
- The duration of sessions and the number of sessions required to address my personal health concerns may vary, and no guarantees will be made to the effectiveness of treatment, nor to the number of treatments required for any given person.

_____ I understand manual therapy sessions are voluntary and for my sole benefit. Because manual therapy should not be performed under certain medical conditions, I affirm that I have stated all known personal medical conditions, and answered all questions honestly.

_____ I understand that if I am pregnant (or have reason to believe I may be), or have an implanted medical device like an IUD, stent, pace-maker, etc... I must tell my practitioner(s) immediately before treatment, and it is my sole responsibility to do so.

_____ I understand it is my sole responsibility to keep the practitioner updated as to any changes in my medical profile, and I assume all risks of participation in the manual therapy session(s), including, but not limited to, risk of medical complications, injury, or death. I expressly waive, release, discharge, and hold harmless Movement Bodywork, and the practitioner(s), of any and all liability claims and demands, including legal fees and costs, as a result of my participation in any activity of any type with Movement Bodywork. I further understand I, or the practitioner, may modify the treatment plan or terminate the treatment session(s) at any time in order to maintain the safety and health of the practitioner and client. I will immediately inform the practitioner if a technique requires modification for my safety and personal threshold of discomfort.

_____ I understand that manual therapy is non-sexual in practice; any illicit or sexually suggestive remarks or advances made by me (the client), perceived or otherwise, will result in warnings and/or immediate termination of the session(s). I further understand I will be liable for payment of the scheduled appointment regardless of reason for early termination.

_____ I understand that any treatment over chest/breast tissues will be discussed and understood beforehand, palpation will be appropriate and minimal, and permission to work over breast tissues will be asked every time with verbal consent given in addition to signing below. I understand that I may withdraw consent at anytime, and may request another person in the room during treatment.

** All cancellations require 24 hours notice or the full session fee may be charged. **
If I have an illness, injury or surgery, I will contact the practitioner so a decision can be made about rescheduling.

By signing below, I confirm I have read, and agree, to the conditions of treatment and give my consent to receive care.

Signature: _____ **Date:** _____
Client Signature (or parent/guardian if under 18 years of age)