Massage TLC Client Consent Form

First Name _____ Initial ____ Last Name _____ D.O.B. _____ Gender ____

Street _____Apt# _____ City _____ State ____ Zip _____

E-mail _____ Occupation _____

Home (_____)_____ Cell (_____)_____How did you learn of Massage TLC? _____

Medical History

☐ Yes ☐ No Cancer?

☐ Yes ☐ No Hemophilia?

☐ Yes ☐ No Osteoporosis?

☐ Yes ☐ No Kidney disorder?

☐ Yes ☐ No Heart condition?

☐ Yes ☐ No Pacemaker, shunt, or stint?

☐ Yes ☐ No Uncontrolled high blood pressure?

☐ Yes ☐ No Thrombosis, phlebitis, or blood clots?

☐ Yes ☐ No On blood thinners / high aspirin doses?

☐ Yes ☐ No Abdominal surgery in the past 2 months?

☐ Yes ☐ No Tuberculosis, or cellulitis?

☐ Yes ☐ No Irritable Bowel Syndrome?

☐ Yes ☐ No Uncontrolled diabetes or lupus?

☐ Yes ☐ No Bone fracture in the past 8 weeks?

☐ Yes ☐ No Eye procedures in the past 72 hours?

☐ Yes ☐ No Lymphoma or lymph nodes removed?

☐ Yes ☐ No Guillain–Barré Syndrome / loss of feeling?

☐ Yes ☐ No Spinal stenosis/spondylitis/sponsylolithesis?

☐ Yes ☐ No **Women:** Pregnant or trying to get pregnant?

☐ Yes ☐ No **Women:** Breast implants in past 9 months?

For any "Yes" answers above, please provide additional details here: _____

_____

☐ Yes ☐ No Laminectomy, spinal fusion, spinal rod surgery—or lordosis or kyphosis?

If so, describe (with dates) _____

☐ Yes ☐ No Herniated or bulging discs, or disc protrusions or extrusions?

If so, identify _____

☐ Yes ☐ No Skin infections, ulcerations, rashes, open cuts, bruises, acne, swelling, sunburn, painful areas, boils, abscesses, inflammation, varicose veins?

If so, describe _____

☐ Yes ☐ No Implants, arthritic joints, osteopenia, hypermobile joints, knee or hip replacements, recent injuries, surgeries, hematomas, bruising, or injections into a joint or muscle?

If so, identify _____

☐ Yes ☐ No Fever and/or any cold or flu symptoms? If so, describe _____

☐ Yes ☐ No **Women:** Are you having heavy menstrual flow?

Is there anything else the therapist should be aware of? _____

_____

Consent for Therapy

The following modalities are offered at Massage TLC, and I will advise the therapist if I would prefer to NOT experience any of these, both verbally and by marking through the item(s):

Massage Therapies— *including: Swedish, Deep Tissue, Hot Stone, Trigger Point, Sports, Prenatal, Ashiatsu Oriental Bar Therapy, Ashi-Thai Stretching, Thermal Connective Tissue Release, Chinese Cupping, Reflexology / Hand & Foot Massage.*

Additional Therapies—*including: Applied Vascular Therapy (BEMER), Emotional Freedom Techniques (EFT), Egoscue® Postural Alignment Therapy, Therasage® Far Infrared Ray Heating Pad, Therasage® Far Infrared Sauna, Enhanced Raindrop Technique, Aromatherapy, AromaDome Essential Oil Therapy, Dolphin Neurostim Microcurrent Point Stimulation, Ultrasound Therapy, Facial Cupping Therapy, Thai Herbal Ball, Crystal Bowl Sound Therapy, Light Therapy, Hot Mitts, Chi Machine, Hot House Far Infrared Ray Dome, Power Eyes Massager, E-Power Energizer, Electro Reflex Energizer, Holosync® Audio Technology, Nutritional Counselling via Quantum Reflex Analysis (QRA), Kinesio Taping.*

Products—*including: BEMER (Distilled) Water, Organic Teas, Premier Research Labs Supplements, Drucker Labs Supplements, Corganics® Relief pain cream, Young Living Essential Oils.*

If I experience any pain or discomfort during a session, I will immediately inform the therapist so the pressure/strokes may be adjusted to my level of comfort.

If I am uncomfortable for any reason I may ask that the therapist cease the therapy and they will end the session.

I am also aware that proper draping will be used at all times during the session unless otherwise agreed to by both the therapist and me.

I have stated all of my relevant physical and medical conditions, and I will keep the therapist updated on my physical health at the start of each visit.

Women: I am aware that the therapist will not engage in breast massage without my consent.
If I desire breast massage, by my initials in the field that follows I give that consent: _____

Client / Parent / Guardian Signature X_____ Date _____

If client is a minor, by my signature above I authorize Roberta Stalvey and/or her assigns to administer massage or other bodywork, and I agree to be present during all treatments.

Therapist's Signature _____ Date _____

Massage TLC

Roberta Stalvey, LMT & Advanced EFT Practitioner
1440 Carrollton Parkway, Suite #16105
Carrollton, TX 75010

Website: http://MassageTLC.com
Email: contact@massagetlc.com
Phone: 972-804-2468

Clients seen by appointment only. No walk-ins.

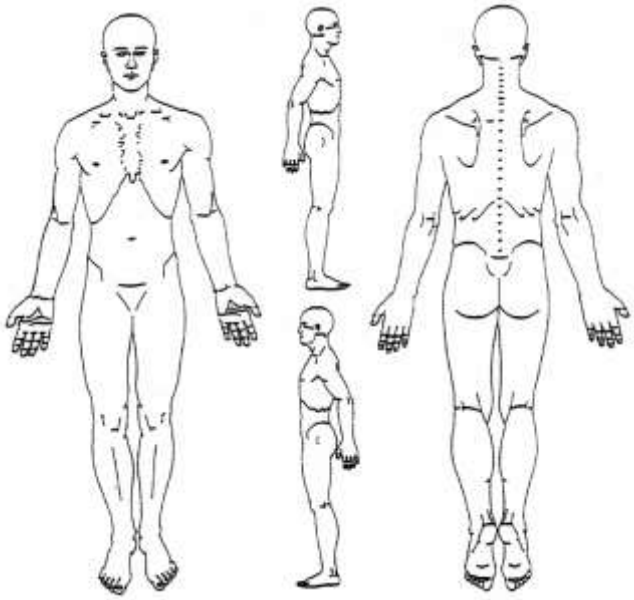
Massage TLC Clinical Intake Form

First Name _____ Initial ____ Last Name _____

What are your goals for this session? _____

On a scale of 0 to 10, what number would you assign to your overall level of stress and/or discomfort? _____

What do you believe might be the cause? _____ When did the pain/stress begin? _____



How are you feeling right now?

Any changes since your last visit?

Any medical changes or anything else the therapist should be aware of before beginning treatment? ☐ Yes ☐ No

If yes, please identify it here _____

Client / Parent / Guardian Signature 𝕏_____ Date _____

Post Session

On a scale of 0 to 10 how are you feeling? _____

Describe: _____

EFT results (if applicable): _____

Did I achieve or exceed your goals? ☐ Yes ☐ No

Is there anything I could have done to make your experience better?

_____

May I contact you in a few days re: your progress?
☐ Yes ☐ No

Is it OK to text you?
☐ Yes ☐ No

Client's Initials: 𝕏 _____

Follow-up Date: _____

Session Duration _____ Therapist's Notes

Min.	B.Body	B.Pad / Loc.	Other / Loc.