ROOTS & BRANCHES THERAPEUTIC MASSAGE AND HERBALS, LLC

Consent for Treatment

Client Name: _____ Date: _____ Date of Birth: _____ Age: _____

Address: _____ Occupation: _____

Phone: _____ Email: _____ Referred by:_____

Physician/Health-care Provider name: _____ Phone: _____

Have you ever received professional massage/bodywork before? Yes ☐ No ☐ How recently? _____
What kind of pressure do you prefer? Light Medium Firm

How do you feel today? Physically: _____ Emotionally: _____

List and prioritize your goals for this session: i.e. reduced stress, pain, stiffness, numbness/tingling, swelling, etc…

_____

_____

List the medications you currently take and symptoms they are for:

Medication	Reason	Medication	Reason

Are you pregnant? Yes☐ No☐ Are you trying to become pregnant? Yes☐ No☐

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema. Please answer honestly, as massage may not be indicated for these conditions.

Circle current or past conditions. Skip over issues that don't apply. Please share details and treatments that seem to work.

Current Past Muscle or joint pain _____

Current Past Muscle or joint stiffness _____

Current Past Numbness or tingling _____

Current Past Swelling _____

Current Past Bruise easily _____

Current Past Sensitive to touch/pressure _____

Current Past High/Low blood pressure _____

Current Past Stroke, heart attack _____

Current Past Varicose veins _____

Current Past Shortness of breath, asthma _____

Current Past Cancer _____

Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____

Current Past Epilepsy, seizures _____

Current Past Headaches, Migraines _____

Current Past Dizziness, ringing in the ears _____

Current Past Digestive conditions (e.g. Crohn's, IBS) _____

Current Past Gas, bloating, constipation _____

Current Past Kidney disease, infection _____

Current Past Arthritis (rheumatoid, osteoarthritis) _____

Current Past Osteoporosis, degenerative spine/disk _____

Current Past Scoliosis _____

Current Past Broken bones _____

Current Past Allergies _____

Current Past Diabetes _____

Current Past Endocrine/thyroid conditions _____

Current Past Depression, anxiety _____

Current Past Memory Loss, confusion, easily overwhelmed _____

Comments: _____

_____

_____

Therapeutic Massage and Cupping Waiver

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that therapeutic bodywork should not be construed as a substitute for a medical examination or diagnosis. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be interpreted as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.

Massage Cupping™ is an ancient technique. The purpose of this technique is to promote health and healing by loosening soft tissue and connective tissue, scarring and adhesions moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. These cups are placed on the skin sometimes using gliding motions and sometimes they're stationary for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into the soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them. I understand there could be temporary skin discolorations after the cups have been stationary on the body. I am aware that these are NOT bruises and that it will dissipate within a few hours to a few days. I understand that all treatments by the massage therapist at this facility are therapeutic in nature. Again, I agree to communicate with the therapist of any physical discomfort experienced. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made to me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____