Miracle Massage Therapy, LLC a Hybrid Healing Center

Name (print): _____ Today's Date: _____

Phone: _____ Date of Birth: _____ Gender: _____

Address: _____

Email: _____ Zip Code: _____

Referred by: _____

Emergency contact: _____ Phone: _____

Consent for Treatment

A. 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.

B. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

C. 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 given should be construed as such.

D. 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.

E. 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.

F. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

G. Understanding all of this, I give my consent to receive care.

Massage Information

Have you ever received professional massage/bodywork before? ..... Yes ☐ No ☐

How recently? _____

What kind of pressure do you prefer? ..... Light Medium Firm

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

_____

What are your massage/bodywork goals?_____

How do you feel today? _____

Health History: please indicate in the space below any of the following health conditions that you currently have (If you are unsure, please ask):

☐ Yes ☐ No … Do you frequently suffer from Stress?
☐ Yes ☐ No … Do you have diabetes?
☐ Yes ☐ No … Do you experience frequent headaches?
☐ Yes ☐ No … Are you pregnant?
☐ Yes ☐ No … Do you have cardiac or circulatory problems?
☐ Yes ☐ No … Are you taking high blood pressure medication?
☐ Yes ☐ No … Do you suffer from epilepsy or seizures?
☐ Yes ☐ No … Do you have varicose veins?
☐ Yes ☐ No … Do you have osteoporosis?
☐ Yes ☐ No … Are you wearing contacts?
☐ Yes ☐ No … Do you bruise easily?
☐ Yes ☐ No … Any broken bones in the past two years?
☐ Yes ☐ No … Any injuries in the past two years?
☐ Yes ☐ No … Do you suffer from arthritis?
☐ Yes ☐ No … Do you have high blood pressure?
☐ Yes ☐ No … Do you have numbness or stabbing pains?
☐ Yes ☐ No … Do you suffer from joint swelling?
☐ Yes ☐ No … Do you have any contagious diseases?
☐ Yes ☐ No … Do you have any allergies?
☐ Yes ☐ No … Are you wearing dentures?

Client Signature: _____ Date: _____

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

Practitioner Signature: _____ Date: _____

Miracle Massage Therapy, LLC

LEB Therapy Only (Bio-Electric):

Please answer the following questions on your **past or present** medical history with a **YES** or **NO**. If you are not sure, answer YES. If any of these items apply to you, we suggest that you consult with a medical doctor prior to participating in bioelectric therapy treatment.

Are you pregnant, or are you attempting to become pregnant? . . . . . Yes ☐ No ☐

Have you ever had or do you currently have …

Heart, lung, kidney failure? . . . . . Yes ☐ No ☐

Malignancy (Cancer)? . . . . . Yes ☐ No ☐

Acute infectious disease? . . . . . Yes ☐ No ☐

Any form of hemorrhagic disease? . . . . . Yes ☐ No ☐

Gestation or menstrual period of women? . . . . . Yes ☐ No ☐

Foreign object in your face or body (such as metals, silicon dioxide, etc.)? . . . . . Yes ☐ No ☐

High blood pressure over 160/110mmHg? . . . . . Yes ☐ No ☐

Body organ(s) removed or missing? . . . . . Yes ☐ No ☐

Internal/external Bleeding? . . . . . Yes ☐ No ☐

Are you in recovery period from cardiac surgery or serious organic heart disease? . . . . . Yes ☐ No ☐

Practitioner's observation/recommendations:

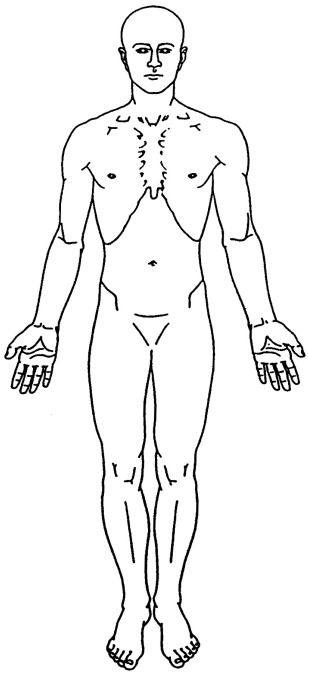
_____

_____

_____

_____

Please mark the diagram using the type and location of areas treated/symptoms.



A = Ache/Sore (痛/痛的)
T = Tension (拉紧)

S = Sharp (锐利的)
B = Burning (燃烧的)
N = Numbness (麻木的)
G = Tingling (刺痛)
M = Spasm (痉挛)