Nancy's Therapeutic Massage
Nancy Satow COTA/L, LMT
Licensed & Certified in Occupational Therapy
Certified Massage Therapist

Deep Muscle • Chronic Pain • Neck and Back Injuries
Arthritis • Sports Injuries • Migraines • Relaxation

610-417-9501

Client Information

Name: _____ Home Phone: _____
Cell Phone: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Referred By: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

General & Medical Information

Please circle yes (y) or no (n)

1. Have you ever experienced a professional massage? Y/N
2. If so, how recently? _____
3. Do you frequently suffer from stress? Y/N
4. Do you have diabetes? Y/N
5. Do you experience frequent headaches? Y/N
6. Do you suffer from arthritis? Y/N
7. Do you suffer from fibromyalgia? Y/N
8. Do you have high blood pressure Y/N
9. If yes, what medication are you taking? _____
10. Do you suffer from epilepsy or seizures? Y/N
11. Do you suffer from joint swelling? Y/N
12. Do you suffer from varicose veins? Y/N
13. Do you have osteoporosis? Y/N
14. Do you have any allergies? Y/N
15. Do you bruise easily? Y/N

16. Have you had any broken bones in the past two years? Y/N

17. Have you suffered any injuries in the past two months? Y/N

18. Do you have any tension or soreness in a specific area?

Please specify _____

19. Do you have cardiac or circulatory problems?

20. Do you suffer from back pain?

21. Do you have numbness or stabbing pains anywhere?

22. Are you very sensitive to touch or pressure in any area?

23. Have you had surgery?

Explain: _____

_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. 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. 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 construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have all my known medical conditions listed and answered all questions honestly. 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 practitioners part should I fail to do so. 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.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

***Consent to Treatment of Minor**: By my signature below I herby authorize Nancy Satow COTA/L, LMT to administer massage, bodywork, or somatic therapy techniques to my child or dependent as she deems necessary.*

Signature of Parent or Guardian: _____ Date: _____

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CLIENT NON-DISCLOSURE AGREEMENT

Please read our Therapeutic massage office's "Client Non-Disclosure Agreement" form which is part of the Health Insurance Portability and Accountability Act of 1996, HIPPAA.

This office has a legal and ethical responsibility to safeguard the privacy of all clients and to protect the confidentiality of their health information. In the course of my treatment at this office, I may come into possession of confidential clients information, even though I may not be directly involved in providing clients services.

I understand that such information must be maintained in the strictest confidence. I hereby acknowledge that, I will not, at any time during or after my treatment with this office, disclose any client information to any person whatsoever or permit any person whatsoever to examine or make copies of any client reports or other documents prepared by me, coming into my possession, or under my control, or use client information, other than as necessary in the course of my practice. I further understand that I will be bound by these same standards and that I will not obtain or use such information for my personal benefit.

When client information must be disclosed with other health care practitioners on the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the clients's care.

I have read and understand this client non-disclosure agreement.

_____ _____

Signature of Client *Date*

11/11