sarasota school of massagetherapy

CLIENT HISTORY AND INFORMATION

Name:_____ Date: _____

Address: _____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Alternate Phone:_____

Email:_____ DOB: _____

Height:_____ Weight:_____ Gender: ❑ Female ❑ Male ❑ Non-binary/Other

Profession:_____

Activities/Hobbies:_____

Emergency Contact Name & Number: _____

CURRENT MEDICAL TREATMENT

Are you currently being treated by a physician or other medical personnel? ❑ Yes ❑ No

If yes, please explain:_____

_____

_____

_____

CURRENT MEDICATIONS - including aspirin, ibuprofen, herbs, supplements, etc.

_____

_____

_____

_____

MEDICAL HISTORY

Check the conditions you have had **previously**; *circle* the conditions you *currently* have:

- ❑ Arthritis
- ❑ Asthma
- ❑ COPD
- ❑ COVID-19 (previous 3 months)
- ❑ Muscle/joint pains
- ❑ Cuts/rashes/bruises
- ❑ Seizure disorders
- ❑ Tension/ stress
- ❑ Varicose veins
- ❑ Vision/hearing conditions
- ❑ Allergies
- ❑ Surgeries
  - ❑ Pins/plates
  - ❑ Pacemaker
  - ❑ Joint replacement
  - ❑ Other
- ❑ Autoimmune/compromised
- ❑ Cancer
- ❑ Blood clots
- ❑ Cardiovascular disease
- ❑ Cerebrovascular Accident/stroke
- ❑ Diabetes
- ❑ Pregnancy
- ❑ Neurological Conditions
- ❑ Open wounds or sores (contagious)
- ❑ Infection
- ❑ Bulging/herniated disk
- ❑ Swelling/edema
- ❑ Unexplained leg pain
- ❑ Other

If yes to any of the above, please explain:_____

_____

_____

I understand that SSMT collects this information for my safety, and for the student to be more effective in treating me.

I understand that massage therapists cannot diagnose, that students cannot treat medical conditions, and that this massage is not a replacement for medical care

I understand massage therapy requires lengthy, close interaction, and that during the session distancing is impossible. I understand the student and supervisors may wear masks, and that HEPA filters in the treatment space will generate noise.

I understand SSMT has taken additional precautions as outlined in the *SSMT COVID-19 Clinic Policies*, but that transmission is still possible. I understand SSMT cannot be held liable and agree to hold SSMT harmless should I develop COVID-19.

I have read the *SSMT COVID-19 Clinic Policies* and agree to them all.

I agree to pay an operations fee in advance and to complete a short evaluation form after the treatment has concluded.

Client Signature: _____ Date: _____

FOR SSMT USE ONLY

Physician's release required ❑ Yes ❑ No

If required, physician's note received ❑ Yes ❑ No