A MINDFUL ROOT
MASSAGE THERAPY

Confidential Patient Intake Form

Client Name_____ DOB_____

Address_____ City/State/Zip _____

Phone (day)_____ (evening) _____

Email_____

Occupation _____ Employer _____

Primary Physician_____ Phone _____

Emergency Contact _____ Relationship_____

Phone _____

How did you hear about us?_____

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If Yes, please list name and use:_____

_____

Are you currently pregnant? ☐ Yes ☐ No

If Yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If Yes, please explain _____

What makes it better?_____

What makes it worse? _____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If Yes, please list:_____

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

Massage Information

Have you had a professional massage before? ☐ Yes ☐ No

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

☐ Other_____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ Yes ☐ No

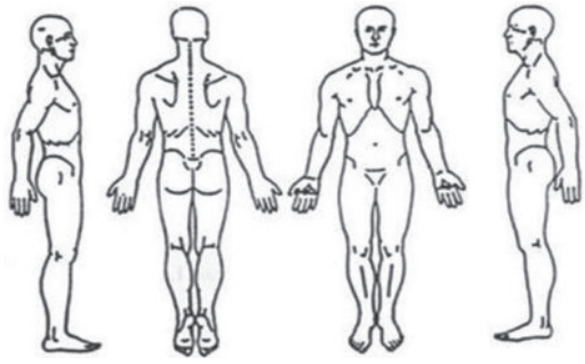
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. I have read and signed the COVID-19 questionnaire.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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Cancellation Policy

A Mindful Root appreciates you and your business, which is why we reserve your appointment time specifically for you. We understand that unforeseen situations occur in our daily lives from time to time that re-arrange or create conflict with scheduling. **In the event you need to cancel or reschedule your appointment, please notify us by phone at least 24 hours in advance of your scheduled appointment.** This allows us to schedule other clients for that time period.

All cancellation notifications that occur less than 24 hours from the scheduled time will be charged 50% of the original service charge. No show/no calls will be charged 100% of the original service charge.

Individuals that arrive 10 minutes passed their scheduled appointment time are subject to a shortened treatment.

Individuals arriving 15 minutes passed their scheduled appointment time will be asked to reschedule.

I have read and agree to the cancellation policy.

Client Signature _____ Date _____

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COVID-19 Policy

The health and safety of my clients is very important and a top priority for me. I am fully vaccinated against COVID-19. I will be limiting the number of daily appointments booked, leaving ample time between treatments for sanitation purposes.

If you are experiencing a fever, cough, or sore throat or any other COVID-19 related symptoms, please reschedule your appointment for when you are no longer symptomatic. I respectfully request, and thank you in advance for wearing a face covering when I arrive for your appointment, and throughout the entire treatment. Masks should be worn until the therapist leaves the place of service. Both therapist and client will be required to use hand sanitizer before each session.

For mobile massage services a private socially distanced space within the home should be determined.

In addition to the Patient Intake Form, a COVID-29 Informed Consent Form must be read and signed by both the client and therapist.

—Bradley Carroll

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COVID-19 Health Information & Informed Consent

Client Name_____ Date _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? ☐ Yes ☐ No
2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? ☐ Yes ☐ No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? ☐ Yes ☐ No
4. Have you traveled anywhere outside of the state in the last two weeks? ☐ Yes ☐ No Location:_____
5. Have you had a new loss of sense of taste or smell? ☐ Yes ☐ No

The following questions are specific to a new aspect of COVID-19 involving blood coagulation:

6. Can you exercise to get your heart rate and respiratory rate up without any problem? ☐ Yes ☐ No
7. Have you had a new onset of muscle aches and pain since the emergence of the virus? ☐ Yes ☐ No
8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? ☐ Yes ☐ No

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided).

I understand that the Novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction. I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance.

I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which i seek care from this office.

Client Signature _____ Date _____

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