LORAN NICASTRO BS, BCTMB, LMBT
MANUAL THERAPIES

CONFIDENTIAL CLIENT INFORMATION/MEDICAL HISTORY
(PLEASE PRINT CLEARLY)

NAME_____DOB_____AGE_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE (_____)_____home work cell TELEPHONE (_____)_____home work cell

EMAIL_____home work

CURRENT OCCUPATION_____HOW LONG_____

REFERRED BY_____TELEPHONE (_____)_____home work cell

EMERGENCY CONTACT_____RELATIONSHIP_____

TELEPHONE (_____)_____home work cell TELEPHONE (_____)_____home work cell

HAVE YOU EVER EXPERIENCED A PROFESSIONAL MASSAGE THERAPY OR BODYWORK SESSION? Yes No

TYPES/FREQUENCY?_____

HAVE YOU EVER EXPERIENCED OTHER TYPES OF ALTERNATIVE HEALTHCARE TREATMENTS SUCH AS CHIROPRACTIC, ACUPUNCTURE, ETC? Yes No

TYPES/FREQUENCY?_____

*PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS, WHETHER ***CURRENT*** OR IF THERE HAS BEEN A ***HISTORY*** OF ANY KIND, AT ANY TIME. IF NEED BE, THERE IS SPACE TO ELABORATE IN MORE DETAIL AT THE END OF THIS SECTION.

PLEASE REVIEW THE FOLLOWING LIST AND CHECK ALL THAT APPLY:

_____STRESS _____HEADACHES _____HEAD PROBLEMS _____JAW PROBLEMS/TMJ _____NECK PROBLEMS _____BACK PROBLEMS _____EXTREMITY PROBLEMS _____ARTHRITIS/BURSITIS

_____VARICOSE VEINS _____OSTEOPOROSIS _____DIABETES _____EPILEPSY/SEIZURES

_____HIGH BLOOD PRESSURE (MEDICATIONS? Yes No) _____LOW BLOOD PRESSURE

_____NUMBNESS/TINGLING _____STABBING PAINS _____HEART ATTACK _____STROKE

_____CANCER _____ALLERGIES _____SINUS PROBLEMS _____FRACTURES _____DISLOCATIONS

_____SURGERIES

HAVE YOU EVER BEEN IN AN ACCIDENT (AUTO OR OTHERWISE)? Yes No

HAVE YOU EVER SUFFERED ANY KIND OF INJURY? Yes No

DO YOU BRUISE EASILY? Yes No

DO YOU HAVE ANY FUNCTIONAL DISORDERS (DIGESTIVE, RESPIRATORY, URO-GENITAL, CARDIO-VASCULAR/CIRCULATORY, NERVOUS, ENDOCRINE, MUSCULO-SKELETAL)? Yes No

DO YOU HAVE ANY CONTAGIOUS DISEASES? Yes No

ARE YOU CURRENTLY WEARING CONTACT LENSES? Yes No

ARE YOU CURRENTLY WEARING DENTURES? Yes No

WHAT IS YOUR PRIMARY COMPLAINT THAT BROUGHT YOU IN FOR TREATMENT TODAY?

_____

ARE YOU SENSITIVE TO TOUCH OR PRESSURE IN ANY GIVEN AREA? Yes No

DO YOU HAVE ANY OTHER MEDICAL CONDITION THAT HASN'T BEEN MENTIONED ON THIS INTAKE FORM?

Yes No

FOR WOMEN ONLY:

ARE YOU CURRENTLY PREGNANT? Yes No IF SO, HOW MANY MONTHS? _____

DO YOU HAVE ANY HISTORY OF PREGNANCIES/CHILDBIRTHS? Yes No IF YES, PLEASE EXPLAIN

(NUMBER OF TIMES/CHILDREN, DATES, COMPLICATIONS, ETC): _____

_____

_____

*PLEASE LIST ANY CURRENT MEDICATIONS AND/OR ANY MEDICATIONS TAKEN IN THE PAST, IF ANY, AND THE REASONS THEY WERE PRESCRIBED:

_____

_____

_____

*PLEASE FEEL FREE TO COMMENT IN MORE DETAIL CONCERNING ANY OF YOUR MEDICAL HISTORY MENTIONED ABOVE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

INFORMED CONSENT FOR TREATMENT

(INCLUDING ALL SUBSEQUENT TREATMENTS)

I UNDERSTAND THAT THE MASSAGE/BODYWORK THERAPIES THAT I WILL RECEIVE ARE PROVIDED TO HELP RELIEVE VARIOUS BODILY ISSUES/DYSFUNCTIONS (TENSIONS, PAIN, SPASMS, ETC), TO BRING ABOUT RELAXATION TO THE TISSUES OF THE BODY, TO INCREASE CIRCULATION, AND TO IMPROVE TISSUE FUNCTIONALITY.

IF I EXPERIENCE ANY PAIN/DISCOMFORT THAT IS INTOLERABLE AT ANY TIME DURING THE TREATMENT, I WILL IMMEDIATELY INFORM THE PRACTITIONER SO THAT THE PRESSURE/TECHNIQUE CAN BE ADJUSTED TO MAKE IT MORE COMFORTABLE FOR ME.

I FURTHER UNDERSTAND THAT MASSAGE/BODYWORK SHOULD NOT BE CONSTRUED AS A SUBSTITUTE FOR MEDICAL EXAMINATION/DIAGNOSIS/TREATMENT, AND THAT I SHOULD SEE A PHYSICIAN OR OTHER QUALIFIED MEDICAL SPECIALIST WHEN APPROPRIATE, BE IT FOR A MENTAL OR PHYSICAL AILMENT.

I ALSO UNDERSTAND THAT MASSAGE/BODYWORK PRACTITIONERS ARE NOT QUALIFIED TO PERFORM SPINAL/SKELETAL ADJUSTMENTS; AND THAT THEY CANNOT DIAGNOSE ILLNESS, DISEASE, OR ANY OTHER PHYSICAL OR MENTAL DISORDER; AND THAT THEY CANNOT PRESCRIBE MEDICAL TREATMENT OR MEDICATIONS; AND THAT ANYTHING SAID THROUGHOUT THE COURSE OF ANY GIVEN SESSION SHOULD NOT BE CONSTRUED AS SUCH.

BECAUSE MASSAGE/BODYWORK SHOULD NOT BE PERFORMED UNDER CERTAIN MEDICAL CONDITIONS (CONTRA-INDICATIONS), I AFFIRM THAT I HAVE STATED ALL OF MY KNOWN MEDICAL CONDITIONS AND ANSWERED ALL QUESTIONS HONESTLY. I AGREE TO KEEP THE PRACTITIONER UPDATED AS TO ANY CHANGES IN MY MEDICAL PROFILE, AND I UNDERSTAND THAT THERE SHALL BE NO LIABILITY ON THE PRACTITIONER'S PART SHOULD I FAIL TO DO SO. I ALSO UNDERSTAND THAT ANY ILICIT 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.

I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO TERMINATE THE SESSION AT ANY TIME AND FOR ANY REASON. AND ALSO THAT IF I CHOOSE TO DO SO, I AM STILL OBLIGATED TO PAY FOR THE ENTIRE SESSION.

CLIENT'S PRINTED NAME: _____

CLIENT'S SIGNATURE: _____

PRACTITIONER'S PRINTED NAME: _____

PRACTITIONER'S SIGNATURE: _____

DATE: _____

COVID-19
INFORMATION, QUESTIONS, INFORMED CONSENT
(ADDITIONAL)

TO MAXIMIZE YOUR HEALTH AND SAFETY, I COMMIT TO TAKING ALL PRECAUTIONARY MEASURES, INCLUDING MONITORING AND PROTECTING MY OWN HEALTH CONDITION AND ACTIVELY LIMITING MY OWN EXPOSURE TO THE COVID-19 VIRUS.

FURTHERMORE, THIS OFFICE FACILITY WILL COMPLY WITH CDC & OSHA GUIDELINES FOR HEALTH AND SAFETY, IN ORDER TO HELP PREVENT THE POSSIBLE SPREAD OF THE COVID-19 VIRUS. THESE GUIDELINES CAN INCLUDE:

-A TEMPERATURE CHECK (WITH A NO-CONTACT FOREHEAD THERMOMETER)

-MASK WEARING (BY BOTH THE CLIENT & PRACTITIONER)

-HAND SANITIZER (FOR BOTH THE CLIENT & PRACTITIONER)

-REGULAR CLEANING & SANITIZING PROCEDURES THROUGHOUT THE OFFICE FACILITY

-REGULAR CLEANING & SANITIZING PROCEDURES THROUGHOUT THE COMMON AREAS OF THE BUILDING, INCLUDING THE BATHROOMS

-CLEAN SHEETS, TOWELS, BLANKETS, PILLOW CASES, AND FACE REST COVERINGS

-AN AIR PURIFIER (IN THE TREATMENT ROOM)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

HAVE YOU EVER TESTED POSITIVE FOR COVID-19? Yes No

IF YES, WHEN DID THIS OCCUR? _____

ARE YOU CURRENTLY WAITING FOR THE RESULTS OF A COVID-19 TEST? Yes No

HAVE YOU RECENTLY BEEN EXPOSED TO SOMEONE WHO HAS COVID-19? Yes No

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER EXPERIENCED ANY OF THESE COMMON COVID-19 SYMPTOMS IN THE PAST SEVERAL MONTHS? PLEASE CHECK ALL THAT APPLY.

_____FEVER _____COUGH _____SORE THROAT _____RUNNY NOSE

_____TROUBLE BREATHING _____HEADACHES (THAT ARE UNUSUAL FOR YOU)

_____DIMINISHED SENSE OF TASTE/SMELL _____FATIGUE _____WEAKNESS

_____MUSCLE SORENESS _____INTESTINAL CRAMPING _____ACUTE DIARRHEA

_____VOMITING _____OTHER DIGESTIVE DISTURBANCES _____RASH

_____PINK EYE _____IMPAIRED BRAIN/NEUROLOGICAL FUNCTIONING

WITHIN THE LAST 2 WEEKS, HAVE YOU TRAVELLED ANYWHERE BY MEANS OF PUBLIC TRANSPORTATION (PLANE, TRAIN, BUS, ETC)? Yes No

WITHIN THE LAST 2 WEEKS, HAVE YOU BEEN EXPOSED TO ANY PUBLIC CROWDS OR GATHERINGS? Yes No

PLEASE READ THE FOLLOWING AND SIGN YOUR NAME IF YOU AGREE TO GIVE CONSENT FOR TREATMENT:

I UNDERSTAND THAT CLOSE CONTACT WITH PEOPLE INCREASES THE RISK OF COVID-19 INFECTION. BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I AM AWARE OF THE RISKS INVOLVED AND GIVE CONSENT TO RECEIVE MASSAGE/BODYWORK THERAPIES FROM THIS PRACTITIONER. ALSO, I AGREE TO KEEP THE PRACTITIONER UPDATED AS TO ANY CHANGES IN MY COVID-19 STATUS.

I FURTHER UNDERSTAND THAT MY NAME/CONTACT INFORMATION MIGHT BE SHARED WITH THE STATE AND/OR A LOCAL HEALTH DEPARTMENT IN THE EVENT THAT A CLIENT OR PRACTITIONER AT THIS OFFICE FACILITY/BUILDING TESTS POSITIVE FOR COVID-19. MY CONTACT INFORMATION WILL ONLY BE SHARED IN THE EVENT THAT IT IS RELEVANT BASED ON SUSPECTED EXPOSURE DATE, AND ONLY FOR APPROPRIATE FOLLOW-UP BY THE HEALTH DEPARTMENT(S).

CLIENT'S PRINTED NAME: _____

CLIENT'S SIGNATURE: _____

PRACTITIONER'S PRINTED NAME: _____

PRACTITIONER'S SIGNATURE: _____

DATE: _____