ARTHRITIS & SPORTS

Orthopaedics • Physical Therapy • Wellness

Name: _____ DOB: _____

Referred By: _____ Occupation: _____

Have you ever experienced a professional massage or bodywork session? ☐ Y ☐ N

If yes, how recently: _____

What are your massage or bodywork goals: _____

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

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

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 n, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, physical therapist, 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 given should be construed as such. 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. 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. 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 hereby authorize Arthritis & Sports' massage therapist to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

Arthritis & Sports | Wellness Studio
21475 Ridgetop Circle, Suite 240 | Sterling, VA 20166
703.349.5100 | www.arthritisandsports.com/wellness-studio

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Please circle yes or no for the following questions:

Y	N		Y	N	
☐	☐	Do you frequently suffer from stress?	☐	☐	Do you bruise easily?
☐	☐	Do you have diabetes?	☐	☐	Any broken bones in the past 2 years?
☐	☐	Do you experience frequent headaches?	☐	☐	Do you have high blood pressure?
☐	☐	Are you pregnant?	☐	☐	Are you taking high blood pressure medicine?
☐	☐	Do you suffer from arthritis?	☐	☐	Any injuries in the past 2 years?
☐	☐	Are you wearing contact lenses?	☐	☐	Do you have tension of soreness in a specific area?
☐	☐	Do you suffer from epilepsy or seizures?	☐	☐	Do you have cardiac of circulatory problems?
☐	☐	Do you suffer from joint swelling?	☐	☐	Do you suffer from back pain?
☐	☐	Do you have varicose veins?	☐	☐	Do you have numbness or stabbing pain?
☐	☐	Do you have any contagious diseases?	☐	☐	Are you sensitive to touch or pressure in any areas?
☐	☐	Do you have osteoporosis?	☐	☐	Have you ever had surgery?
☐	☐	Do you have any allergies?			

Please list any other medical conditions that our massage therapist should know about:

_____

_____

If you answered yes to any of the above questions, please explain:

_____

_____

_____

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