Client Intake & Agreement/Consent Form

● emerald vine massage ● massage@emeraldvine.net ● www.emeraldvine.net ● p. 206.347.0777 ● f. 888.254.3281 ●

personal information

Name: _____ Date of Birth: _____

Email: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Referred By: _____

current health information

Reason for initial visit: _____

Do you sit for long hours (e.g. at workstation, computer, driving)? ..... ☐ Y ☐ N

If yes, describe: _____

Do you perform any repetitive movement (e.g. at work, during hobbies/sports)? ..... ☐ Y ☐ N

If yes, describe: _____

Do you experience stress in your work, family, or other aspect of your life? ..... ☐ Y ☐ N

If yes, describe: _____

Are you experiencing tension, stiffness, discomfort or pain? ..... ☐ Y ☐ N

If yes, describe, and mark location(s) on the figures to the right:

_____

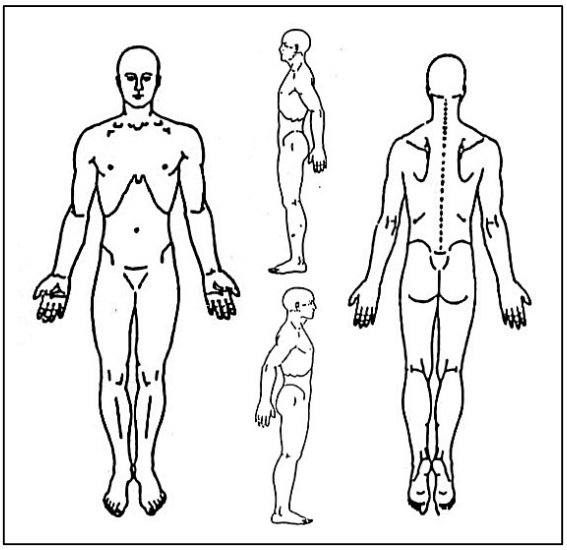
_____

_____

_____

_____

_____



List any known allergies: _____

_____

List any current medications: _____

_____

Current conditions:

☐ Allergies
☐ Arthritis
☐ Disc Problems
☐ Cold, Fever
☐ Fibromyalgia
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Numbness
☐ Open Lesions, Cuts
☐ Other

☐ Pregnant (or trying to become pregnant)
☐ Phlebitis
☐ Rashes
☐ Ringworm
☐ Sciatica
☐ Sprains, Strains
☐ Whiplash
☐ Skin Condition

Describe conditions: _____

_____

_____

Health care providers currently being seen:

☐ Medical Doctor
☐ Physical Therapist
☐ Massage Therapist
☐ Talk Therapist
☐ Acupuncturist

☐ Chiropractor
☐ Naturopath
☐ Osteopath
☐ Other

For what conditions: _____

_____

_____

_____

(continued on reverse side)

massage experience

How long have you been receiving massage therapy? _____ Frequency: _____

Likes/dislikes: _____

What are your goals for treatment? _____

client agreement

I _____ voluntarily consent to receive massage therapy from Shaina M. Akidau, LMP. I am aware of the benefits and risks of massage and and choose to receive massage treatment. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of on this form and will inform my practitioner of any changes in my health status.

I agree to pay all charges at the time of service and all associated fees, as determined by the bank, for insufficient funds. I understand that, for non-emergencies, I must give a minimum of 24-hours notice to cancel my appointment time and that failure to do so will results in a $50 charge for the time reserved. In the event that I arrive late for my appointment, I understand that the massage will end at the time scheduled and that full cost of the massage session will still apply. While I may receive a reminder email in the days prior to my appointment, in the event that I do not receive this courtesy, I understand that I am still responsible for remembering my appointment time.

I understand that Shaina M. Akidau will maintain the confidentiality and privacy of my massage sessions and all documents related to my treatment at Emerald Vine PLLC. This information will not be shared unless I give expressed, written permission or in the event that it is determined that I may be of harm to myself or others.

Signature: _____ Date: _____

client preferences & consent

I _____ voluntarily consent to receive therapeutic massage from Shaina M. Akidau, LMP, with the specifications listed and initialed below.

I agree to communicate with my Shaina M. Akidau, LMP, to provide safe and effective treatment to the best of their skills and knowledge. I understand that that the intent of the massage is therapeutic and not sexual. I understand that I may at any time direct Shaina M. Akidau, LMP to avoid or stop touching specific areas on my body and that I can discontinue treatment at any time and for any reason. I understand that I may request the massage to be given through a drape, rather than directly on my body, at any time for any reason. I understand that I have the right to provide a witness to be in the room with me while I receive massage.

I understand that the permissions given in this document are required in accordance with Washington Administrative Code regarding coverage/draping (WAC 246-830-560) and breast massage (WAC 246-830-005, 246-830-555), and may be added or withdrawn at any time for any reason.

I understand that therapeutic massage of the chest to access the pectoralis major & minor, subclavius, serratus anterior, intercostals may require going through, under, or around breast tissue and am voluntarily requesting chest massage for the purpose(s) of (*please initial below*):

___ posture support
___ movement support
___ breath support
___ circulation support
___ treatment of neck pain/injury
___ treatment of shoulder pain/injury
___ treatment of rib pain/injury
___ stress relief
___ holistic body presence
___ other (_____ _____ _____)

I understand that, regardless of gender identity, my expressed permission is legally required to receive undraped chest massage. As such, I give my permission for massage of my (*please initial below*):

___ undraped chest (with nipples & areolae uncovered while chest muscles are massaged)
___ draped chest (with nipples & areolae covered by a drape at all times)
___ covered chest (with entire chest covered and massage performed through the drape)
___ n/a (no permission to massage chest muscles given)

Signature: _____ Date: _____

(continued from reverse side)