Name ________________________________ ____ Male ____ Female DOB ______________

Address _____________________________________ City _______________ State ________ Zip __________

E-mail: ____ Best time to reach you _____________

Home Phone ( )_____________ Cell Phone ( ) ______________ Work Phone ( )_____________

Occupation _________________________________

How did you hear about me? Who referred you? ____

In case of emergency: ____________________________________ Phone ( )_________________________

Please take a moment to carefully read the following information, fill out the questionnaire and sign where indicated. If you have a specific medical condition or specific symptoms, massage / bodywork may not be advisable.

1. **Have you ever experienced a professional massage or bodywork session?** __ Yes __ No

When? ____________ Frequency? ____________ Modalities (Techniques) received? __________________

Reason for calling/Purposes of Massage (relaxation/addressing an injury)? ____________________________

What kind of pressure do you prefer? __ light __ medium __ firm

2. **Have you ever experienced an energetic healing session (Reiki, chakra balancing, crystal healing, sound healing, etc.)?** __ Yes __ No

When? ____________ Frequency? ____________ Modalities (Techniques) received? __________________

What is your reason for seeking energetic healing work? ____

____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

__ Yes __ No Do you frequently suffer from stress?
__ Yes __ No Do you have diabetes?
__ Yes __ No Do you experience frequent headaches?
__ Yes __ No Are you pregnant?
__ Yes __ No Do you suffer from arthritis?
__ Yes __ No Are you wearing contact lenses?
__ Yes __ No Are you wearing dentures?
__ Yes __ No Do you have high blood pressure?

__ Yes __ No Are you taking high blood pressure medication?
__ Yes __ No Do you suffer from epilepsy or seizures?
__ Yes __ No Do you suffer from joint swelling?
__ Yes __ No Do you have varicose veins?
__ Yes __ No Do you have any contagious diseases?
__ Yes __ No Do you have osteoporosis?
__ Yes __ No Do you have any allergies?
__ Yes __ No Do you bruise easily?
__ Yes __ No Any broken bones in the past two years?
__ Yes __ No Any injuries in the past two years?

__ Yes __ No Do you have tension or soreness in a specific area?

Please specify: ____

__ Yes __ No Do you have cardiac or circulatory problems?
__ Yes __ No Do you suffer from back pain?
__ Yes __ No Do you have numbness or stabbing pains?
__ Yes __ No Are you sensitive to touch or pressure in any area?
__ Yes __ No Have you ever had surgery? Explain below.
__ Yes __ No Other medical condition, or are you taking any medications I should know about?

Additional Comments/Concerns: ____

____

I understand that the massage / bodywork I may receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I also understand that any energy work given may involve a natural hands-on method of energy balancing for the purpose of stress reduction, relaxation and promotion of natural healing. I understand very clearly that these treatments are not intended as a substitute for medical or psychological care. I further understand that energy work / massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that energy work / 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.

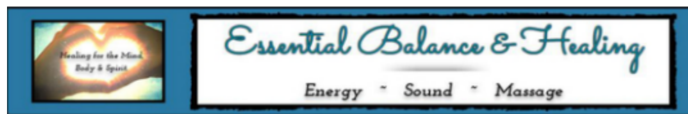
Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability 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.

Essential Balance & Healing works within the California Senate Bill SB-577. It is the responsibility of the Reiki Practitioner to inform clients that Reiki is a compliment to traditional Western medicine provided by doctors, nurses and other licensed medical professionals. Practitioners are not licensed physicians and Reiki does not require a license by the state. All clients sign this as an Acknowledgement and Consent form to receive services.

Client Signature ______________________________ Date ___________________

Practitioner Signature ______________________________ Date _____________________

COVID-19 DISCLAIMER: I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner. ***Also see additional COVID-19 Health Information & Informed Consent Form***



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 ☐

MEMBER
Associated Bodywork & Massage Professionals

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 have been offered a copy of this consent form. _____________

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): _______________________ Date: ____________

MEMBER
Associated Bodywork & Massage Professionals