Botanica Wellness Sanctuary
1940 E 18th Ave
Denver, Co 80206
720.398.2050

Massage Consent

Name:________________________________ Email:___________________________________

Address:_______________________________ City:_________________ St_____ Zip_____________

Birthday: _____________________ Phone:______________________

Emergency Contact (Name & Relationship):______________________ Phone:_____________________

HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

MUSCULO-SKELETAL
- ◻ Headaches
- ◻ Joint stiffness/swelling
- ◻ Spasms/cramps
- ◻ Broken/fractured bones
- ◻ Strains/sprains
- ◻ Tendonitis
- ◻ Back, hip pain
- ◻ Shoulder, neck, arm, hand pain
- ◻ Leg, foot pain
- ◻ Chest, rib, abdominal pain
- ◻ Problems Walking
- ◻ Jaw pain/TMJ
- ◻ Bursitis
- ◻ Arthritis
- ◻ Osteoporosis
- ◻ Scoliosis
- ◻ Bone/Joint Disease
- ◻ Other:_________________

CIRCULATORY/RESPIRATORY
- ◻ Dizziness
- ◻ Cold feet/hands
- ◻ Cold Sweats
- ◻ Swollen Ankles
- ◻ Blood Clots
- ◻ Stroke
- ◻ Heart Condition
- ◻ Asthma
- ◻ High/Low Blood Pressure
- ◻ Lymphedema
- ◻ Other:_________________

SKIN
- ◻ Rashes
- ◻ Allergies
- ◻ Athlete's Foot
- ◻ Other:________________

DIGESTIVE
- ◻ Nervous Stomach
- ◻ Diverticulitis
- ◻ IBS
- ◻ Crohn's Disease
- ◻ Food Allergies/Sensitivities
- ◻ Colitis
- ◻ Other:________________

NERVOUS SYSTEM
- ◻ Numbness/Tingling
- ◻ Twitching
- ◻ Fatigue
- ◻ Chronic Pain
- ◻ Sleep Disorders
- ◻ Ulcers
- ◻ Paralysis
- ◻ Shingles
- ◻ Epilepsy
- ◻ Chronic Fatigue Syndrome
- ◻ Multiple Sclerosis
- ◻ Muscular Dystrophy
- ◻ Parkinson's Disease
- ◻ Spinal Cord Injury
- ◻ Other:_________________

REPRODUCTIVE SYSTEM
- ◻ Pregnancy (Current)
- ◻ PMS
- ◻ Menopause
- ◻ Fertility Concerns
- ◻ Other:_________________

OTHER
- ◻ Loss of Appetite
- ◻ Forgetfulness
- ◻ Confusion
- ◻ Depression
- ◻ Difficulty Concentrating
- ◻ Hearing Impaired
- ◻ Visually Impaired
- ◻ Diabetes
- ◻ Fibromyalgia
- ◻ Post/Polio Syndrome
- ◻ Cancer
- ◻ Infectious Disease: ___________________
- ◻ Congenital/Acquired Disabilities:____________
- ◻ Surgeries:____________
- ◻ Other:_______________

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HEALTH INFORMATION

Who may we thank for referring you, or how did you hear about us?____

If you learned of us online, which website did you use?____

Have you ever had massage therapy before? If so, what did you like the most/least?___________________________

____

What are your expectations for this session?____

Present Symptoms: What condition(s) would you like to improve?______________________________________

When was the first onset of your current condition?____

What activity or situation induced your symptoms?____

What activities aggravate your symptoms?____

Is this condition getting progressively worse? If yes, please explain:____

____

What have you done to get relief?____

Has there been a medical diagnosis for your condition? If yes, what were the results?__________________________

____

Are you currently under medical/therapeutic treatment?____

List any medications (including aspirin) and/or nutritional supplements that you are taking on a daily basis:_________

____

Describe the exercise activities you participate in (please include frequency):__________________________________

List other types of therapies that you receive (i.e. chiropractic care):____

Please tell me about your preferences during your massage (i.e. deep v. light pressure, sensitivities to certain smells, etc...):____

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CLIENT WAIVER

(Please check the boxes below and sign this form at the bottom of the page.)

□ I have completed these forms to the best of my knowledge and will inform the massage therapist of any change in my health.

□ I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical or emotional disorder, nor perform spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.

□ I understand that my massage therapist is a professional practitioner, who is licensed by the State of Colorado through Department of Regulatory Agencies and will uphold their strict ethics and regulations.

□ I understand that if the massage therapist starts a session late, she/he will make up the time at the end of the session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me will not be penalized.

□ I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I don't provide 24-hour notice to cancel or reschedule.

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Thank you! By taking the time to fill out these forms, you have taken the first step in your recovery. We now have valuable information pertaining to your current health that we can utilize to improve your well-being. Please don't hesitate to ask any questions pertaining to this questionnaire or to ask additional questions that you might have regarding our education and background as holistic care providers and massage therapists. We look forward to working with you! By signing below you agree that we have discussed and that you are aware of our practice policies.

Client: ________________________________ Date: ________________________

Office Use Only

CMT: ________________________________ Date: ________________________

Notes: