CLIENT INFORMATION & HEALTH HISTORY

HAVE WE MET?

Full Name _____ Birthdate (M/D/Y) _____ Pronouns _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

↳ I usually follow up a few days after a session to check on how you're feeling.

If this is ok with you, please indicate what method of contact you prefer: ☐ Email ☐ Text ☐ Call

Emergency Contact _____ Relation _____ Phone _____

Current medications (include aspirin, herbs, supplements, etc) and purpose of each _____

_____

I ONCE HAD THIS MASSAGE.

Have you received massage/bodywork before? ☐ Yes ☐ No How often? _____

What form(s) or style(s)?

☐ Assisted Stretching	☐ Counterstrain	☐ Deep Tissue	☐ Craniosacral	☐ Lomi Lomi	☐ Lymphatic
☐ Medical	☐ Myofascial Release	☐ Orthobionomy	☐ Reflexology	☐ Rolfing	☐ Shiatsu
☐ Sports	☐ Structural Integration	☐ Swedish/Spa	☐ Thai Yoga	☐ Trager	☐ Other

What is your chief goal for bodywork today? _____

Is there a secondary goal for today's session? _____

Is there any region(s) of your body you do NOT want massaged? _____

I'M AS MAD AS HELL AND I'M NOT GOING TO TAKE THIS ANYMORE!

Please mark/describe your energy level. I----------I

BLACK HOLE AVERAGE SUPERNOVA

Please mark/describe your stress level. I----------I

MIDDLING AVERAGE EXTREME

Please mark/describe your activity level. I----------I

18 YEAR OLD CAT AVERAGE 2 YEAR OLD HEELER

List all injuries/surgeries **within the past 5 years**. Please include all motor vehicle collisions, sprains, and thrown backs to the best of your memory. _____

_____

List all injuries/surgeries **older than 5 years** (Yes, including that weird wrist fracture you had when you were 11).

_____

_____

CLIENT INFORMATION & HEALTH HISTORY

GENERAL HEALTH: PLEASE MARK ANY CONDITION THAT APPLIES TO YOU **NOW** OR IN THE **PAST**.
CIRCLE APPLICABLE CONDITION WHERE TWO OR MORE ARE LISTED ON THE SAME LINE.

NOW	PAST	CONDITION
		GENERAL
☐	☐	Allergies:_____
☐	☐	Depression / Anxiety / PTSD
☐	☐	Headaches / Migraines
☐	☐	Insomnia / Sleep Disturbance / Fatigue
		RESPIRATORY & CARDIOVASCULAR
☐	☐	Asthma / Breathing Issue
☐	☐	Heart Disease / Irregular HB / Chest Pain
☐	☐	High / Low Blood Pressure
☐	☐	Poor Circulation / Swollen Ankles/Wrists
☐	☐	Sinus / Upper Respiratory Problems
☐	☐	Stroke / Bleeding Disorder
		MUSCLES & JOINTS
☐	☐	Arthritis / Stiff or Painful Joints
☐	☐	Broken Bones / Sprains / Strains
☐	☐	Jaw Pain / TMJD — Right / Left / Both
☐	☐	Osteoporosis
☐	☐	Scoliosis / Spinal / Disc Problems
☐	☐	Tendonitis / Tendonosis / Bursitis
		SKIN
☐	☐	Psoriasis
☐	☐	Rashes / Herpes / Athlete's Foot

NOW	PAST	CONDITION
		NERVOUS SYSTEM
☐	☐	Chronic Pain
☐	☐	Dizziness / Ringing in the Ears
☐	☐	Head Injuries / Concussions
☐	☐	Loss of Memory / Confusion
☐	☐	Numbness / Tingling
☐	☐	Still Paying Attention?
☐	☐	Shooting / Traveling Pain (Sciatica, CTS)
		DIGESTIVE
☐	☐	Abdominal Pain / Ulcers
☐	☐	Bladder / Kidney Dysfunction
		OTHER NOT IDENTIFIED ELSEWHERE
☐	☐	Pregnant - Trimester ? _____
☐	☐	Cancer / Tumors
☐	☐	HIV / Hepatitis Exposure
☐	☐	Covid-19 / Long Covid
☐	☐	Other: _____
		VICES
☐	☐	Alcohol - Sometimes / Regularly
☐	☐	Caffeine - Sometimes / Regularly
☐	☐	Exercise - Sometimes / Regularly
☐	☐	Marijuana - Sometimes / Regularly
☐	☐	Sugar - Sometimes / Regularly

Please read and initial:

_____ I have listed all my known medical conditions and will inform the massage therapist of any change in my physical health between sessions.

_____ I acknowledge I have full authority and responsibility, regardless of the reason, to determine if and when I may want the treatment paused, changed or stopped.

_____ I understand the therapist reserves the right to refuse services for reasons of safety, or should my needs exceed the therapist knowledge, skill and abilities or scope of practice.

_____ I understand that I have the option to bring someone in the room as a witness/support during treatment, and it is my responsibility to provide this person for any given session.

Print Name_____ Signature_____ Date _____

CONSENT & AGREEMENTS

POLICIES

Cancellation and Lateness: Your appointment time is reserved exclusively for you. If you should need to reschedule or cancel your appointment up to 24 hours in advance, you can do so through the Chidori Massage website or by calling/emailing/texting me. Any changes/cancellations within 24 hours of your appointment time will result in your card on file being charged for the full amount of the session.

If you are running late, please drive safely. I will wait 20 minutes before moving on to another project unless you notify me. Upon your arrival, we will work through the end of your appointment time with no change in fee. If you are 20 or more minutes late without calling/texting me, your appointment will be cancelled and your card will be charged for the full amount of the session.

Payment: Payment is due at the time of your session. Cash, Venmo, and XBT/ETH is accepted for all services and certificates. Credit cards are also accepted, but not preferred. If you are planning to use your flex spending account/health savings account, L&I, or PIP claim please let me know before your appointment.

Scents: In consideration of patients with sensitivities and allergies, please refrain from wearing perfume, cologne, or other scented products.

By signing below you acknowledge your understanding of and agreement to the above policies.

Print Name_____ Signature_____ Date _____

INFORMED CONSENT & PERMISSIONS

General intention and procedure: As your massage therapist, I, Charli Hamilton, LMT, will assess your general health and tissue status in order to determine any cautions, contraindications, or necessary adjustments for massage, but I do not diagnose illness, disease, or any other physical disorder. I do not prescribe or perform medical treatment, nor spinal manipulation. Massage does not substitute for medical examination or treatment. **It is your responsibility to report changes in your health and to give feedback during treatment so we can work together as a team to optimize your experience.**

Consent for Care and Treatment & Acknowledgment of Policies: I, the undersigned, do hereby agree and give my consent for Charli Hamilton, LMT to furnish care and treatment considered necessary and proper in assessing or treating my physical condition. I have read the preceding disclosure information and have been given the opportunity to ask questions clarifying its contents. I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to pay for services in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. I understand the contents of this disclosure and agree to abide by these policies.

Print Name_____ Signature_____ Date _____

CONSENT & AGREEMENTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION IS SECURED, HOW IT MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING BELOW.

The following are the confidentiality and privacy practices of Chidori Massage (hereafter known as "the clinic").

CLIENT RIGHTS

Clients may request, in writing, restrictions on records - limiting the way the clinic uses or discloses their medical information for treatment, payment, or healthcare operations or limiting access to their information by someone who is involved in their care. If the request is reasonable and legal the clinic will agree to the request and honor the restriction.

Clients may request, in writing to view or obtain a copy of their records. The client may request that corrections be made if they identify errors or mistakes. Access to records will be made during regular business hours within 30 days of receipt of written request and a fee may be charged for copying and sending requested records. Requested records are sent standard US Mail unless the client requests them to be sent via express mail (at client's expense).

A client may, at any time, revoke, in writing, permission to use or disclose medical information. If permission is revoked, medical information will no longer be used or disclosed for the reasons covered by the initial written authorization. That said, the client understands that the clinic is unable to take back any disclosures that were made with permission given prior to a written revocation and that in any event the clinic is required to retain records of the care that was provided.

USE OF RECORDS

Client records are used to document client health and treatment session information. All records when not in use are maintained in a double-locked, unattached network storage, secured in the office. Client treatment records may be shared with primary care providers who are involved in patient's health care.

DISCLOSURE OF RECORDS

Client records and information are only released to anyone outside of the clinic with written authorization from the client unless compelled or required by federal, state or local laws or regulations (such as court order, subpoena, warrant, summons, discovery request, or other lawful process). Client information may be disclosed when necessary to prevent a serious threat to client health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat from materializing. Client medical information may be disclosed for health oversight agency activities if and only if required by law. These activities may include audits, investigations, inspections and licensure.

CHANGES TO THIS NOTICE

The clinic reserves the right to change the terms of this notice at any time. The clinic reserves the right to apply revisions or changes to this notice effective for medical information already on file as well as any information received in the future. A copy of the current notice will be posted at the clinic office for client review. The notice will contain the effective date at the top of the page.

CONTACT INFORMATION

If questions or concerns arise about this notice or client privacy rights, or to file a complaint, please contact:

Charli Hamilton, LMT, owner
5470 NW Shilshole Ave #404, Seattle, WA 98107 charli@chidorimassage.com (206) 800-1030

If concerns or complaints cannot be resolved directly, clients may file a complaint with the Secretary of the Department of Health and Human Services (DHHS). There is no penalty for filing a complaint.

I (please print) _____ have received, read and understand this policy as it relates to receiving massage from Chidori Massage. By signing below I authorize / grant permission for the clinic to use and disclose my health information in accordance with this notice.

Signature_____ Date _____