A Touch Of Health And Wellness, LLC

Vicki Stoddart-Walther, LMT, ACMT, BCTM Massage Therapist, Mechanotherapist
WI Lic LMT 4906-146 ABMP-ACMT 826569 Board Certified- BCTM 586576-10 NPI 1649586868

Name			Date
Address			Email
Town	State	ZIP	Referred By:
Phone:	Cell		I give consent for text/email appointment confirmations & reminders ○ Initials please
Date of birth	Height	Weight	Do you wear ○hearing aids ○dentures ○contacts ○orthotics? ○Have a pacemaker?
Occupation	Company		How physically demanding is your life/work? Light/ Moderate / Heavy / Repetitive

Previous massage experience: ○Yes ○ No Frequency: What is your preference for pressure? Light / Moderate/ Firm / Deep

Reason for coming: ○ Surgical Recovery/Rehabilitation Concurrent with PT? ○ Treatment/Pain relief ○ Other:

Primary / Referring Health Care Provider: Name Address Phone

Do you see ○Chiropractor ○Physical Therapist ○Pain Management ○Other:
How often?

Health History

Have you had any major illness in the past? Yes No
If yes, please describe: _____

Have you ever had surgery? Yes No
If yes, please describe: _____

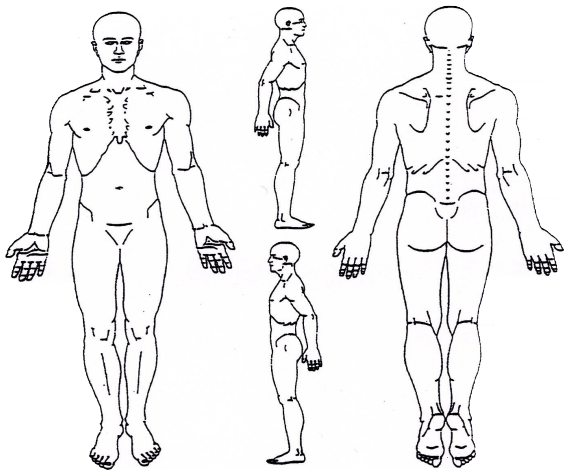
Are you taking any medications? Yes No
If yes, please describe: _____

Are you under a physician's care presently? Yes No
If yes, please describe: _____

Do you have/had any of the following (please circle any that apply):

Diabetes	Allergies	High/Low Blood Pressure	Varicose veins	Arthritis	Sciatica
Stroke/ TIA	Asthma	Carpal Tunnel	HIV/Aids	Hepatitis	Migraines
Headaches	Osteoporosis	Spinal Problems	Immune Deficiency	Leg Cramps	Foot Pain
Epilepsy	Anemia	Tinnitus/ Ringing in ears	Concussion	Whiplash	Cancer
Neck pain	Joint pain	Hearing/Vision Loss	Fluid retention	Bruise Easily	Painful joints
Heart Attack	Tendonitis	Sleeping problems	Loss of balance	Slipped Disc	Pinched Nerve
Muscle Spasm		Muscle Tightness	Pins/needles	Pregnant	Chronic pain
Limited Movement		Fractures/pins/wires	Injuries/Accidents	Other _____	

Present Symptoms Describe your current problem and how it began



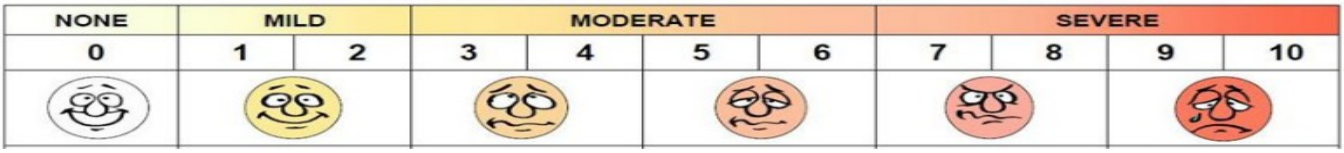
Onset date _____

Is this? □Work related □ Auto related □ N/A

How often are your symptoms present?
□Constant (76 – 100% of day, incessant, debilitating)
□Frequent (51-75% of day, often, interference)
□Oppressive (26-50% of day, often, intermittent, pauses)
□Infrequent (0-25% of day, occasionally, hit-or-miss)

Describe the nature of your pain:
□Sharp □ Dull ache □ Shooting □ Burning □Tingling □ Throbbing

Please rate the level of your pain by marking a **B** for Best, **W** for worst and **N** for right now on the image



Please check the appropriate statement(s):

No pain No Interference	MILD Pain present but does not limit activity	UNCOMFORTABLE TROUBLESOME Can do most things with rest periods	MISERABLE DISTRESSING Unable to do some activity due to pain	INTENSE HORRIBLE Unable to do most activity due to pain	WORST PAIN UNBEARABLE Unable to do any activity due to pain
Activity tolerance	Can be ignored	Interferes with tasks	Interferes with concentration	Interferes with basic needs	Bed rest required

Is it worse in the □ Morning □ Evening □ At Night **Is it relieved by** □ Rest □ Positioning □ Ice □ Heat

How is your condition changing? □ Getting better □ Not changing □ Getting worse

In general, your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Who have you seen for this condition before today? □No One □Medical Doctor □Massage Therapist

□Chiropractor □Physical Therapist □Acupuncturist □Other _____

What treatment did you receive and when?_____

_____

I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and nothing said in the course of the session(s) given should be construed as such. Because massage therapy is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all known conditions and have answered all questions honestly. I agree to update any changes in my medical profile, and understand that there is no liability on the massage therapist's part should I forget to do so.

Name (Please print) _____

Signature _____ Date _____

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INFORMED CONSENT FORM (Completed by each individual)

Please read the following and sign below that you have understood and agreed to the statements:

- ✔ Massage Therapy is the assessment of the soft tissues and joints of the body and their treatment by means of soft tissue manipulations, hydrotherapy and self-care programs to enhance relaxation and well being, reduce pain caused by muscle tension and/or muscle imbalance, increase range of motion, improve circulation.
- ✔ I understand massage therapy is not a substitute for medical treatment or medication, and it is expected I concurrently work with my primary health care provider for any condition I might have.
- ✔ I have completed a health history in which I have informed the massage therapist of all known conditions and medications and I will keep them updated on any changes.
- ✔ I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy.
- ✔ Records are confidential. Written authorization is required to release any information.
- ✔ Areas of your body to be treated will be discussed prior to treatment. The therapist will explain reasons for and ask for consent before applying massage to the pectoral area. The genital/perineum are never massaged.
- ✔ All areas of the body remain draped (covered) except for the area currently being worked on, Treatment may also be provided over clothes. If this is your preference please wear loose fitting clothes that afford for movement and a sports bra
- ✔ You have the right to refuse, modify or terminate treatment at any time without explanation, the therapist reserves the same right. If you experience pain or discomfort during the session, immediately communicate that to the therapist so that the treatment can be adjusted.
- ✔ Payment is due at the time of treatment. Personal checks payable to A Touch of Health and Wellness LLC, cash, credit card, HSA debit card.
- ✔ We require 24 hours cancellation notice. Reminder emails are sent 2 days before scheduled appointments for your convenience. Text reminders are sent 1 day before. Missed appointments will be billed and are due upon receipt. Appointments can be scheduled, changed or moved 24/7 using the online scheduling tool at www.vickiwalther.massagetherapy.com
- ✔ The general benefits of massage, possible contraindications, treatment plan and treatment procedures have been explained to me. I understand I may ask questions at any time.

I have read the above and feel that I may make an informed choice.

Name _____

Signature _____Date _____