Manos de Luz

Client Intake Form

The information collected in this form will be used only for the purpose of designing an appropriate massage therapy program for you and will not be disclosed to any third party without your consent.

General Information

Name _____ email: _____

Date _____ D.O.B. _____ Age _____ Marital Status _____

Address City, ST Zip _____

Phone _____ Mobile _____ Work _____

Occupation _____ Employer _____

In case of emergency, please notify: Name _____ Phone _____

Medical History

Current or Previous major illnesses _____

Current or Previous injuries or accidents _____

Please check if any of the following are relevant to your medical history:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Flu/Cold
- ☐ Headaches
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Previous MVA/trauma
- ☐ Osteoporosis
- ☐ Scoliosis/Lordosis
- ☐ Skin Disorders
- ☐ Sinus Problems
- ☐ Varicose Veins
- ☐ Any infectious conditions _____
- ☐ Other _____

Females Only - *please mark if you are or are trying to get pregnant* ☐ _____ weeks

Are you currently under the care of a physician? ☐ No ☐ Yes *if yes,* _____ (Name) _____ (Phone)

Are you currently taking any medications? ☐ No ☐ Yes *if yes, please list* _____

We reserve the right to request a doctor's clearance before allowing you to receive massage therapy services.

Current Condition/Information

Purpose/Reason for today's visit _____

Are you allergic to any nuts or oils? ☐ No ☐ Yes _____

For injuries/pain:

Areas of any discomfort/pain _____

How long have you had this pain/injury? _____

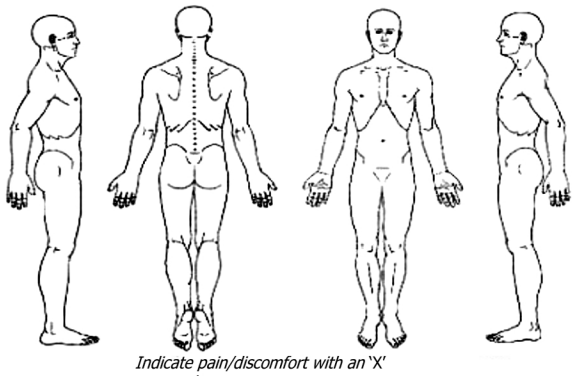
Have you sought out other therapies/treatments? ☑ No ☐ Yes

if yes, list _____

*** what do you think is causing injury/pain?** _____

Do you exercise regularly? ☐ No ☐ Yes

Type _____ *Frequency* _____



Indicate pain/discomfort with an 'X'

How did you hear about us? *Please circle one.*

Drive By ☐ Event ☐ Which one? _____

Internet ☐ Friend/Family Name? _____ Other _____

Hijama Intake Form

Name: _____ Age: _____ Date: _____

Address: _____ Phone #: _____

Email address: _____

Emergency contact: _____ Phone #: _____

Are you currently on your period? Yes☐ No☐ Are you menapausal? Yes☐ No☐

Is it possible you are pregnant? Yes☐ No☐

Do you have any children? Yes☐ No☐ If yes, how many? ____ Are you breastfeeding? Yes☐ No☐

Do you take any medications? Yes☐ No☐ If yes, which? _____
When was last time taken? _____

Are you currently feeling sick with any cold or flu symptoms? Yes☐ No☐

Are you anemic? Yes☐ No☐

Do you have any skin disorders, or recent sunburn? Yes☐ No☐

Do you have any blood-clotting disorders? Yes☐ No☐

Do you have any allergies, in particular to any oils (olive, coconut, or black seed), or latex? Yes☐ No☐
If yes, to what? _____

Do you have any chronic illnesses, such as diabetes, high blood pressure, fibromyalgia, seizures, or cancer?
Yes☐ No☐ If yes, please explain, including how long you have had this condition:

_____

Have you had any significant bodily injuries or operations? Yes☐ No☐ If yes, where on the body?
_____
_____

Do you experience pain or discomfort in any part of your body? Yes☐ No☐
If yes, where? _____
_____

Have you ever had cupping before? Yes☐ No☐ Wet☐ Dry☐

Do you have any questions, concerns, health complaints, or health goals you would like to address in your cupping session? Please explain here: _____
_____

Signature: _____ Date: _____

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Child Waiver for Massage

All persons under the age of 18 are required to have a parent or guardian fill out this form.
By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) at our facility. You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). You will also be required, if needed, to assist the minor in preparing for his/her treatment(s). We may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor. You also agree that you have completed the Intake Form and have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

PLEASE PRINT CLEARLY:

I _____, certify that I am the parent or legal guardian of

_____, who is _____ years of age as of today. I have completed the

Intake Form for the above-mentioned minor and informed the therapist of all relevant medical history and concerns. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

Print Name _____ Signature _____

Date

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Consent Form for Massage

I understand,

- The massage therapist is state-licensed.
- The policies and procedures, have been given a copy and fully plan to comply with what has been stated for the protection of both the massage therapist and the client.
- The relationship between the client and massage therapist is confidential and all information provided to the therapist will be kept confidential.
- That massage therapy in this relationship is solely for the purpose of therapeutic massage and that the massage therapist also has the right to be free from any unwanted, harmful, offensive and/or inappropriate physical contact.
- That I will be professionally and properly draped with a sheet at all times during the massage and will not be naked on the massage table at anytime. That breast and genital areas are not massaged under any circumstance and that buttocks, lower hips and lower back will be massaged with permission from client.
- I have the right to request or require that the room environment or massage being performed may be modified, changed or stopped at any moment and have control in this relationship and service.
- The information I have provided has been accurate and I agree to update the therapist of health changes before the start of each new massage session.
- It may be necessary to obtain permission from a health care provider to receive or continue massage therapy treatments with any new or existing health conditions. The therapeutic massage is ancillary treatment, not primary medical treatment.
- The benefits as well as possible discomforts involved of massage that have been explained to me. If anything feels wrong or painful I have the power to say something. Any questions and concerns can be discussed at anytime during the massage session.
- By signing this form, I also give consent to receiving future massages. I have read this form, and hereby freely give my permission to be massaged. If a minor, I have been informed in the presence of my guardian.

_____ _____

Print Name Client's Signature

_____ _____

Date Therapist's Signature

Manos de Luz

Policies and Procedures

Massage Appointments

Please arrive for your onsite massage appointments on time. Services may be shortened depending on how late or unready you are for your scheduled time allotted. In any session you may pay extra to extend the massage if schedule allows and more time is desired.

Cancellation/No Show Policy

We do ask for at least $25 of a deposit to hold your spot for the massage. Not showing for the appointment and not communicating will result in loss of that deposit. Grace will be given for emergencies but this is to prevent loss of sessions and time that could have been filled with another client. If communicated ahead of time we can hold your deposit for future sessions.

Informed Consent

Prior to each massage session, your treatment plan will be discussed with you. At the first visit, you will receive a consent form which will need to be signed stating that you have read the information, understand and agree to comply with the professional massage therapy policies and procedures.

Payment Policy

All massages must be paid for before or directly after the massage session. I will receive payments in cash, card or by apps such as Venmo or CashApp. We are not taking any insurance at this time.

Scope of Practice

As a Licensed Massage Therapist, this profession is held to the highest standards of American Massage Therapy Association and National Certification Board for Therapeutic Massage and Bodywork.

Massage Therapy is a profession in which the therapist applies manual techniques and may apply related therapies with the intention of positively affecting the health and well-being of the client.

Massage therapists cannot prescribe medications or diagnose medical conditions nor are they allowed to provide treatment for a specific condition without doctor's supervision. The massage therapist is required to refer you for diagnosis to follow physician's orders.

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Policies and Procedures

Respect for Client's Needs and Boundaries

The environment for your massage should be comfortable. If you wish to change the environment such as music volume, temperature of room, decrease essential oil use, etc. you have the position of authority to change everything as you wish. I believe that you are the expert for your unique session and should be an active creator in this collaboration with me through good communication.

During the massage, you should communicate if you are uncomfortable or need an adjustment of pressure at any time. This is very important for your treatment plan. Also, the client may choose to refuse any methods, stop the massage and leave at any time.

Professional Boundaries

Requests for sexual activity **will never tolerated**, will be viewed as solicitation and reported accordingly. If this occurs, sessions will be ended and such client will not be rescheduled. Attempts of sexual interaction or discussion of any kind between the client and the massage therapist is never appropriate. The therapist also has the right to end the session at any moment and leave.

Confidentiality and Conversation

The discussion between massage therapist and client is completely confidential. Professional expertise may be shared but we prefer not to discuss topics of political, private or sexual nature.

Existing and New Medical Conditions

It is your responsibility to keep the massage therapist informed of any medical treatment currently being taken and to provide written permission from the physician, chiropractor, physical therapist, etc. that the massage may be continued if any treatment or medications require permission from a doctor for massage, cupping and healing sessions.

It is also your responsibility to keep the massage therapist informed of any new accidents or changes related to health conditions. Please provide notes from health care providers and updates for chart.

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Notice of Privacy Policy

This notice describes how your medical information may be used and disclosed, how to attain access to your own information, as well as your rights. Please review it carefully.

Treatment: Health information may be viewed and used by the massage therapist for the session or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. The results of the therapy evaluations and procedures can be available to you upon request at any time. For your own treatment and management of any medical condition, it is important you are fully aware of the treatments being performed in your sessions.

Wellness Plan: Creating a wellness plan includes looking at your body in your chart and visualizing the changes overtime as we continue sessions together. This is an important part for maintaining treatment.

Legal Request: As required by law and upon legal request, your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate any investigations and to comply with any government mandated reporting. Your health information may be disclosed to public health agencies also as required by law. Please communicate any issues you may have with this.

Personal contact information: Your contact information (phone and email) may be used for appointment reminders, future sessions, birthday greetings, newsletters, promotions and events. You may request your own preference for how to communicate and contact you in the future. Your emergency contact person will be contacted for any emergency that occurs on site and during services.

Workers compensation: Your health information may be disclosed to the appropriate persons in order to comply with the laws related to workers' compensation or similar programs that may provide benefits for work-related injuries or illness.

Insurance: Currently we don't regularly take insurance.

You have certain rights under the federal privacy standards which include:

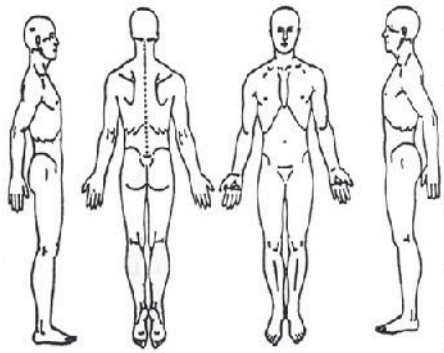
- The right to request restrictions on the use and disclosure of your health information
- The right to receive confidential communications concerning medical treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an account of how and whom your information was disclosed
- The right to receive a printed copy of this notice

_____ _____

Signature Date

FOR MASSAGE THERAPIST USE

Client Name_____



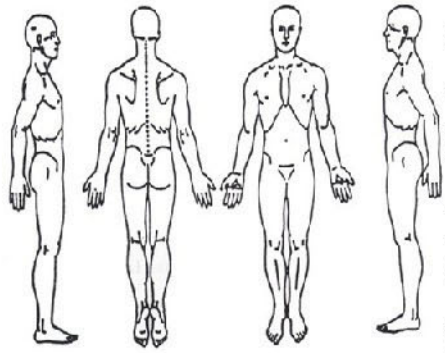
Date_____ Session #_____

S:_____

O:_____

A:_____

P:_____



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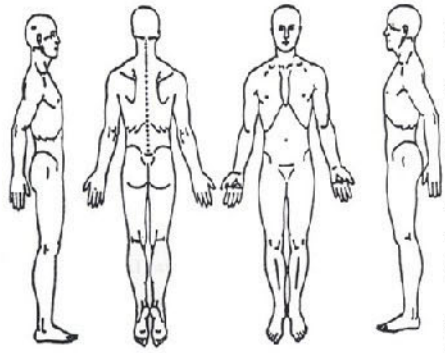

Date_____ Session #_____

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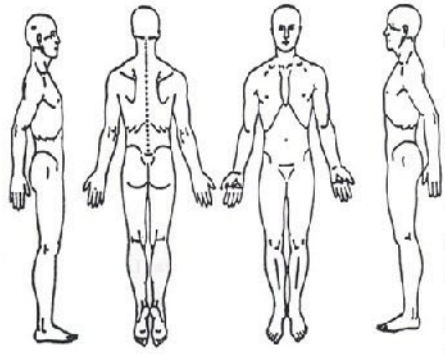

Date_____ Session #_____

S:_____

O:_____

A:_____

P:_____

Final Notes:_____