Kineticare Massage Therapy

Specializing in Therapeutic, Prenatal & Pediatric Massage

Seeing clients in Texas School of Massage Therapy, 17045 El Camino Real, Ste. 120, Houston, TX 77058 ***281-658-1571***

Patient Name: _____ Date of Birth:_____/_____/_____

Age:_____ [ ] Male [ ] Female Occupation:_____

Emergency Contact:_____ Emergency Phone: ( ) _____

Address:_____ Email: _____

City:_____, State_____ Zip:_____ Cell Phone: ( )_____

Referred by:_____ Home/Work Phone: ( )_____

Type of Massage Requested (*please circle at least one*):

Swedish/Relaxation Deep Tissue Trigger Point Pregnancy

Warm Stone Cold Mitten Friction Ice Massage Pediatric/Infant

Other:_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork, may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

□ Yes □ No Are you currently under a doctor's care? If so, please list the name and phone number of your doctor:

_____ Reason:_____

□ Yes □ No Are you currently taking any medications: If so, please list the medication and the purpose:_____

_____

□ Yes □ No Are you wearing any contacts, dentures, prosthesis of any kind, or medical devises?_____

□ Yes □ No Do you currently have any type of skin rashes, open wounds, injuries or bruises?_____

□ Yes □ No Do you currently have a cold/flu, fever, severe pain or anything contagious?_____

□ Yes □ No Do you have any allergies or sensitivities to lotions, foods, medications, environmental allergens?_____

□ Yes □ No Are you sensitive to touch or pressure?_____

□ Yes □ No Have you had any accidents, injuries, hospitalizations or surgeries?_____

□ Yes □ No Are you sensitive to scents, light, temperature, sound?_____

Please explain in detail to any of the above marked "yes": _____

Please review the list below and check those conditions that have affected your health currently, recently or in the past.

□ Joint Pain or Swelling	□ Scoliosis	□ Headaches
□ Diabetes	□ Seizures / Epilepsy	□ Heart Conditions
□ Broken / Dislocated Bones	□ Bruise Easily	□ Insomnia
□ Cancer	□ Asthma / Breathing Problems	□ Constipation / Diarrhea
□ Chemical/Alcohol Dependency	□ Depression/Emotional Disorders	□ TMJ Disorder
□ ADD/ADHD	□ Developmental Disorders	□ Surgery
□ Autism/ Asperger's Syndrome	□ Down Syndrome	□ Cerebral Palsy
□ Muscular Dystrophy	□ Multiple Sclerosis	□ Rett Syndrome
□ Anorexia	□ Dyslexia	□ Other

Please describe in detail any of the items/conditions checked above:

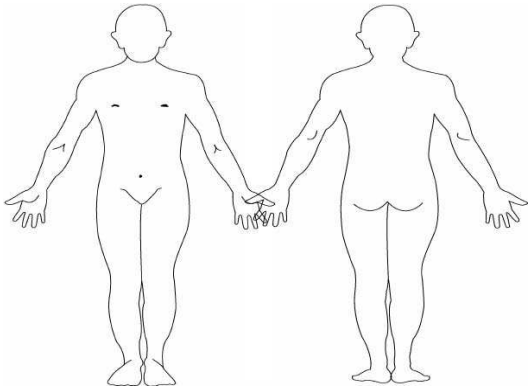
_____

_____

Why are you here today?_: _____

_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING
Mark the areas on this body where you feel the described Sensations with a **circle** and **X** areas to avoid.



Consent to Treatment of a Minor:

By my signature below, I hereby authorize Kineticare Massage Therapy, Tammy Krogman, LMT, to administer massage therapy techniques to my child or dependent as they deem necessary.

I hereby give Tammy Krogman, LMT permission to speak with my child's pediatrician/doctor/counselor/therapist if there are any issues of concern.

Signature of Parent or Guardian:

_____

Date:_____

Client/Practice Bill of Rights for Massage

I understand that the massage therapy I receive is provided for the basic purpose of relaxation, stress reduction, increasing circulation and/or for the relief of muscular tension. If I experience any pain or discomfort during the 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 I may ask the therapist to end the session and that the session will end immediately. I further understand that massage therapy 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 massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I understand the massage therapist prescribes neither medical treatment nor pharmaceuticals.

I understand that my massage session/sessions will include the basics of Swedish massage techniques including effleurage, petrissage, friction, vibration, tapotement and joint movement applied in a full body routine to the soft tissues of the anterior and posterior trunk, upper and lower extremities, hands and feet, face and scalp. Basic principles of deep tissue, myofascial release and triggerpoint therapy may also be utilized. I understand that the therapist will not engage in breast massage of female clients without written consent of the client and a written request from the client's physician. I understand that draping will always be used during my massage therapy sessions. The Genital, Gluteal Cleavage and the Female Breasts (unless Rx'd as above) must remain draped at all times.

Understanding that massage is contraindicated 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.

I understand that if I am uncomfortable for any reason, I may ask the therapist to end the massage and the therapist will end the session. I understand that if the therapist feels uncomfortable for any reason, the therapist may end the session. I understand that the therapist must immediately end the massage session if a client initiates any verbal or physical contact that is sexual in nature.

I do hereby release Kineticare Massage Therapy, Kineticare LLC and/or Tammy L. Krogman, LMT from any liability pertaining to any present or future physical or mental condition I may have.

I also understand that Kineticare Massage Therapy requires a 24-hour notice if I am not able to make my appointment and if I fail to cancel in a timely matter and/or do not show up to my appointment I will be billed for the entire session.

Client Signature:_____**Date**:_____

To Be Completed by the Therapist:

Type of massage/techniques used for this client :

_____

_____

Parts of the body to be massaged and/or avoided due to indications & contraindications: _____

_____

Therapist's Signature & Date: _____

Tammy L. Krogman, LMT, MTI Texas License Numbers MT 109620, MI 2464, CE 1684