



BODYWORK & MASSAGE AGREEMENT

PERSONAL DATA

Name: _____ Date of Birth: _____ Date: _____
 Email: _____ Cell Phone: _____
 Occupation/Employer: _____ Type of work: _____
 Primary Health Provider: _____ Phone: _____
 Permission to consult with primary provider? Please initial if yes _____

BODYWORK & MASSAGE HISTORY

Have you ever received professional bodywork? _____ If yes, frequency: _____ Date of last treatment: _____
 Type of bodywork received (Massage, Craniosacral, Lymph Drainage, etc....) _____
 Describe main reason for visit: _____

 Describe secondary reason for visit: _____

 If injury, date of injury: _____
 What results do you want from your treatment? _____

 Prioritize areas of your body that you would prefer to be worked/massaged: _____

 Are you currently seeing a medical practitioner? Please explain if yes: _____

 Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes: _____

 List stress reduction and exercise activities. Include frequency: _____

PREVIOUS HISTORY (Include year & treatment received)

Surgeries: _____

 Accidents: _____

 Major Illnesses: _____

It is my choice to receive bodywork: I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my wellbeing is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status.

SIGNATURE: _____ **DATE:** _____

Informed Consent for Therapeutic Massage

I, _____, voluntarily consent to receive full body, therapeutic massage, with the specifications listed and initialed below.

I am aware that (1) the intent of the massage is therapeutic and not sexual, and (2) I have the right to:

- Discontinue the entire massage session, or any part of the session, at any time and for any reason
- Request the massage to be given through a drape rather than directly on my body, at any time and for any reason
- Provide a witness who will be in the room with me while I receive massage

Please initial those marked below. Please ask your therapist any questions you have regarding treatments or let them know if you are uncomfortable in some way regarding the requested consent.

Consent for Breast/Chest Massage:

Massage of Breast Tissue: Some types of treatment require massage of the breast tissue. Specifically, Manual Lymphatic Drainage for the treatment of edema requires massage of both the affected and unaffected side. WAC 246-830-555 requires your special written and verbal consent for breast massage, your massage therapist to have 16 hrs. of specialized training for this work and that any massage involving the nipple and areola requires a doctor's prescription specifying the medical need for massage therapy of the areola/nipple or your special written and verbal permission separate from breast massage. Prior to each massage, your massage therapist will thoroughly explain what is going to be massaged and why. In order to achieve treatment goals, your therapist might deem it appropriate to work on muscle or connective tissue near or underneath breast/chest tissue (for example, pectoralis or intercostal muscles). Your therapist will do their best to avoid breast tissue and minimize pressure.

Even though you consent to breast massage today you can choose not to receive it at any point of your treatment or limit the massage. Please let them know any time treatment feels uncomfortable in any way.

Please initial where your consent is given:

- I consent to breast massage. _____
- I have provided the required doctor's referral, and/or consent to massage of the areola / nipple of my right / left breast. _____
- I consent to my breasts/my chest being touched during the massage treatment for the purpose of working with surrounding or deep structures. _____
- I prefer not to be touched on or near my breasts/chest. _____

Consent for Intraoral Massage:

Intraoral Massage: Your therapist may deem it advisable to work inside your mouth to achieve your treatment goals. She/he has the required licensing endorsement.

I consent to intra-oral work. _____

Consent for Draping Variance:

State law requires that draping is provided during a massage and ensures that the following areas will not be exposed during a massage: Breast/chest, genitals, and gluteal cleft. There are several exceptions:

- Temporary removal of draping can occur for the gluteal cleft area and breasts with written, verbal and signed informed consent.
- Breast draping may be removed for the duration of the full session with written, verbal and signed informed consent.

Breast/chest: I consent to my breast being uncovered during breast massage. _____

Torso (males only): I consent to having my torso uncovered/undressed during the full massage _____

Assistance with dressing/undressing: I require assistance with undressing and dressing, which may expose my breasts and gluteal cleft area. I consent to assistance. _____

DRAPING DESCRIPTIONS: Genitals and gluteal cleft below the tip of the tailbone are always draped.

- *Minimal draping:* Chest/breasts may be uncovered at any or all times during the session, based on client reference.
- *Moderate draping:* Chest/breasts may be covered most of the session but uncovered while being specifically massaged.
- *Conservative draping:* Chest/breasts remain covered always.

My draping preference is: Minimal _____ Moderate _____ Conservative _____

Consent for Perineal-Pelvic Massage:

Perineal Massage: Your therapist may deem it advisable to work on your perineal area to achieve your treatment goals. She/he has the legally required 16 hrs. of specialized training for this work. Prior to each massage, your massage therapist will thoroughly explain what is going to be massaged and why. Massage of muscle attachments located on the pubic bone and the pelvic bones located between the legs. Genitals are always avoided. This massage may be done through drape or on skin.

Even though you consent to perineal massage today you can choose not to receive it at any point of your treatment or limit the massage. Both written and verbal consent must be provided.

I consent to massage of the perineal area. _____

I understand that I have the right to rescind my consent and refuse any of the above treatments at any time, even in the middle of a treatment session. The consent is valid until I inform my therapist that I want to change it.

I have received a copy of the consent form. _____

Patient or Guardian Name: _____

Patient/ Guardian Signature: _____ **Date:** _____

Massage Therapist Name: _____

Massage Therapist Signature: _____ **Date:** _____