anna scire
massage therapist

Name: _____ Phone: _____

Email: _____ D.O.B: _____

Address: _____City: _____State: _____ Zip:_____

Occupation: _____ Referring Physician: _____

Primary Complain:

_____

_____

Existing medical conditions:

_____

Were you ever diagnosed with cancer? If yes, what treatments have you undergone?

_____

Current medication:

_____

Previous injuries, surgeries and when:

_____

**I understand that there is a 24hour cancellation policy and if I arrive late the original end time will be the same.**

I understand that Massage Therapists do not perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect to do so. I agree to hold harmless, release, and indemnify this licensed and certified Massage Therapist against and all liability arising from the application of massage therapy.

# INFORMED CONSENT

I understand that Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organisation (WHO); that it is contagious and may be contracted from various sources;
that it has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process, "Informed Consent," involves my understanding and agreement regarding recommended care and the benefits and risks associated with the provision of health care.

I understand that treatment in this office may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19, or other infectious diseases can be transmitted.

I understand that I am opting for an elective treatment that may not be urgent or medically necessary and that I have the option to defer my treatment to a later date. I understand the potential risks associated with receiving bodywork during the COVID-19 pandemic and I agree to proceed with my desired treatment at this time.

I confirm that I am not experiencing any of the following symptoms:
Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea.

Travel increases my risk of contracting and transmitting infectious diseases, such as the flu and COVID-19. I verify that I have NOT traveled in the past 14 days internationally or within the United States.

I am informed that the therapist and the rest of the practitioners have implemented preventative measures to reduce the spread of COVID-19 or other infectious diseases. However, I acknowledge and willingly consent that there is an inherent risk of infection and give permission to you and the staff of this office to proceed with providing care.

Name:_____ Date:_____

Signature: _____