# Practically Magik LLC
## Massage Guidelines and Expectations

1. Massage sessions will begin and end at the scheduled time. Sessions that begin late due to the client's late arrival will end at the scheduled time and the client will be billed for the full time.
2. All clients will be treated with respect and dignity. Personal and professional boundaries will be respected at all times.
3. Clients must provide an accurate health history and agree to inform their therapist of any updates or changes to their health/medical condition.
4. Any client with a contagious condition including common cold, influenza, stomach flu, coronavirus, meningitis, shingles, contagious skin conditions, etc. must not come into the office, but call to inform the therapist before scheduled appointment time. Clients may reschedule their appointment after the contagious condition has resolved.
5. Clients with signs of symptoms of an active systemic or localized infection (e.g. fever, sore throat, swelling, etc.) at the time of a scheduled massage are asked to notify their therapist and reschedule their appointment.
6. Massage therapists only provide therapeutic massage and modalities that are within the scope of practice for this licensed profession. Clients with acute injuries or conditions that are outside of the scope of practice for massage should consult with their doctor.
7. All clients will be appropriately draped with a sheet at all times during the massage session. Only the area(s) of the body that are currently being worked will be exposed. The genital area is never exposed or massaged.
8. Client privacy and confidentiality will be maintained at all times.
9. Any client who arrives under the influence of drugs or alcohol will be asked to leave.
10. This is a non-smoking, odor-neutral massage office.
11. Clients are expected to be clean and have showered prior to receiving massage (on same day).
12. All clients are provided with a competent and professional massage that focuses on the needs of each individual client.
13. Harassment of any kind is not tolerated and the session will be terminated if this occurs, or if the practitioner's safety is compromised in any way.
14. Clients are asked to avoid eating a heavy meal during the two hours prior to receiving massage.
15. Appointments are confirmed between one to two days prior to the scheduled appointment.

I have read, fully understand and will abide by the massage guidelines and expectations listed above.

_____

Client Printed Name

_____ _____

Client Signature Date

4405 East-West Hwy. #509 Bethesda, MD 20814 1(410) 656-2442

# Massage Health History Form

The information requested below will assist us in providing you with safe treatments. Please ask your therapist if you have any questions about the information being requested. All information provided below will be kept as confidential unless allowed or required by law. Your written permission will be required to release any information.

## Client Information

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

---

## Health Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anxiety / stress | ☐ yes | ☐ no | Muscle weakness | ☐ yes | ☐ no | **Notes**: _____ | |
| Bleeding disorder | ☐ yes | ☐ no | Neuropathy | ☐ yes | ☐ no | _____ | |
| Blood clot | ☐ yes | ☐ no | Osteoarthritis | ☐ yes | ☐ no | _____ | |
| Bruise easily | ☐ yes | ☐ no | Osteoporosis | ☐ yes | ☐ no | _____ | |
| Bursitis | ☐ yes | ☐ no | Phlebitis/varicose veins | ☐ yes | ☐ no | _____ | |
| Cancer / tumor | ☐ yes | ☐ no | Rheumatoid arthritis | ☐ yes | ☐ no | _____ | |
| Depression | ☐ yes | ☐ no | Sciatica | ☐ yes | ☐ no | | |
| Diabetes | ☐ yes | ☐ no | Seizures | ☐ yes | ☐ no | | |
| Fibromyalgia | ☐ yes | ☐ no | Stroke / CVA | ☐ yes | ☐ no | | |
| Hearing loss | ☐ yes | ☐ no | Tuberculosis | ☐ yes | ☐ no | | |
| High blood pressure | ☐ yes | ☐ no | Tendinitis | ☐ yes | ☐ no | | |
| Low blood pressure | ☐ yes | ☐ no | TMJ disorder | ☐ yes | ☐ no | | |
| Kidney disease | ☐ yes | ☐ no | Vertigo / dizziness | ☐ yes | ☐ no | | |
| Multiple sclerosis | ☐ yes | ☐ no | Vision impairment | ☐ yes | ☐ no | | |

Any skin conditions? ☐ yes ☐ no _____

Neurological conditions? ☐ yes ☐ no _____

Heart condition? ☐ yes ☐ no _____

Autoimmune disorder? ☐ yes ☐ no _____

Digestive problem? ☐ yes ☐ no _____

Endocrine disorder? ☐ yes ☐ no _____

Respiratory disorder? ☐ yes ☐ no _____

Areas of swelling? ☐ yes ☐ no _____

Frequent headaches? ☐ yes ☐ no _____

Areas of numbness or decreased sensation? _____

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

Any current infectious or contagious conditions? (e.g. HIV, TB, fungal infections, shingles, warts, etc.) ☐ yes ☐ no

If yes, please list: _____

Are you taking any medications? If yes, please list: _____

Any allergies or hypersensitivities? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Any implants? (e.g. pacemaker, insulin pump, metal) ☐ yes ☐ no What, where? _____

Are you you currently under medical supervision or receiving other medical interventions?
If yes, please describe: _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____
_____

Please describe any other injuries or health conditions: _____
_____

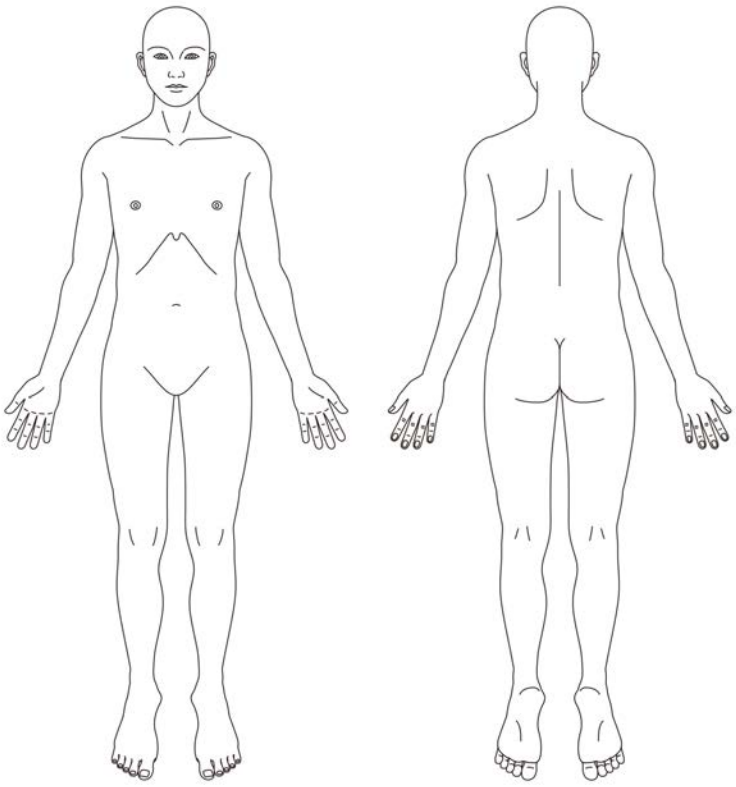
---

Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem _____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

*Please indicate any areas of pain or discomfort*



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form accurately and truthfully to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date _____

Therapist Signature _____ Date _____