BRIDGETOWN BODYWORK

Aarisa Smith, LMT #15732 ~ 443 NE Knott St. ~ Portland, OR 97212 (760) 613 – 5022

CLIENT HEALTH INFORMATION

Date:__________________

Name (legal)		Pronouns (circle)	she/her he/him they/them xe/xem other:_______
Name (for use)		Contact #(s)	
Address		Email	
City, State		Referred by:	
Zip		Date of Birth	

Emergency Contact		Relationship		Phone #	

PLEASE CHECK IF APPLICABLE (leave blank if not) AND DESCRIBE

Allergies (Skin & Other)		
Injuries		
Surgeries (type & date)		
Auto/Other Accidents (date/description/treatment)		
Heart Conditions, High/Low Blood Pressure		
Cancer (Type/Date/Treatment)		
Varicose Veins		
History of Stroke		
Epilepsy/Seizures		
Skin Conditions		
Current Pregnancy		
Arthritis		
Osteoporosis		
Asthma		
Medications (name & purpose)		
Contagious Conditions		
TMJ		
Diabetes		

Signature____Date________________

Parent/Guardian Signature (If Under 18)____________________________Parent/Guardian Phone#_____________

What physical activities do you engage in/how do you use your body on a typical day? ____________________________

____

Other Medical Conditions or anything else you would like me to know?____

____

How frequently do you receive massage?________________________________Date of last massage?_______________

Current areas of concern?____

____

Any treatment received or remedies attempted for this issue? ____

____

Activities which help/make worse?____

____

Physician/Chiropractor/Physical Therapist Information (If Applicable)____

____

Have you experienced any traumatic or frightening event in child or adulthood, or have other concerns around touch which might have impact on how we work together? **Yes / No** If so, do you have any insights on the best way to work together so you feel comfortable & in control - things to do or avoid? ______________________________________

____

_____ I understand that the bodywork practitioner **does not diagnose** illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, **nor does he/she perform any spinal manipulations**, though occasional movements may occur in the course of normal soft tissue work.

_____ I understand that massage therapy and bodywork services offered today and in the future are **not substitutes for medical examination**, diagnosis, or care and it is recommended that I see a medical practitioner for any physical ailment that I may have. I understand that any **information provided by the therapist does not represent a medical suggestion, is not diagnostically prescriptive** in nature, and I am fully responsible for doing my own research or consulting a specialist as indicated before undertaking any actions from such information.

_____ **I certify that I do not have any untreated medical conditions and that the above information is complete and accurate. I agree that it is solely my responsibility to notify the massage therapist of any changes in my health or medical condition.**

_____ By signing this release, I hereby **waive and release** Aarisa Smith and Bridgetown Bodywork from any and all liability, past, present, and future relating to massage therapy and bodywork.

_____ I understand the therapist may end the session for inappropriate behavior and I will still be financially responsible for the full session,

_____ I understand that **my information is not disclosed without my written consent** (or consent of parent/guardian) **unless required by law**, that the below provisions constitute consent in those circumstances, and that I may revoke consent at any time. I understand I have been provided the Notice of Privacy Practices, and may at any time request to see that notice, which may be revised periodically.

_____ I understand that if I cancel my session with less than 48 hours notice, that I will be responsible for the cost of the full session, and that if insurance is filed for a session that **I am financially responsible** should the claim not be paid within 6 months for any reason.

_____ I understand that this facility is **fragrance free** and I will refrain from applying any fragranced products, including deodorants, hair spray, perfume, and anything else, the day of my session, including, where possible, items laundered with fabric softener.

_____ I understand that if I choose to receive **cupping therapy or gua sha that there may be marks** associated with the treatment, and I understand that this treatment is not appropriate for individuals on blood thinners or with bleeding disorders such as hemophilia or sickle cell anemia and will update the therapist if my medication/health status changes at any time.

_____I acknowledge it is **my responsibility to communicate** with the therapist if anything is uncomfortable during the session as well as any changes to my health status and information (the therapist really appreciates this!!!).

_____I **authorize communication to the unsecured email** provided about appointment times and other treatment related information.

_____I **authorize communication by text** to the cell-phone number provided about appointment times and other treatment related information.

_____I **authorize voice mail messages** to the phone numbers provided regarding apointments and treatment related information.

_____I authorize release of my records to my other medical providers, and any attorneys or insurance companies involved in any claims for which Bridgetown Bodywork/ Aarisa Smith LMT 15732 is billing.

_____I authorize any applicable insurance company to pay directly to Aarisa Smith, LMT all benefits for sessions that may be covered, and hereby consider this an assignment of benefits to Aarisa Smith, LMT/ Bridgetown Bodywork. I further authorize Aarisa Smith, LMT/Bridgetown Bodywork to provide all information my insurance company(s) request regarding treatment. All services not covered or allowed by insurance are my full financial responsibility, and will be paid within 30 days of my notification of the insurance determination.

____I **authorize written and verbal communication with my medical providers** regarding my care.

____I authorize communication with the listed individual(s)or organizations ____

regarding my (circle or cross out) treatment, appointment times, billing, other subjects that may have been discussed.

Signature____Date_________________

Parent/Guardian Signature (If Under 18)________________________________Parent/Guardian Phone#_____________

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CLIENT COVID UNDERSTANDING AND CONSENT

____ I understand that close contact with people increases the risk of infection from COVID-19, and acknowledge that I am aware of the risks involved and the safety protocols being followed, and give consent to receive massage from this practitioner. I will not hold Bridgetown Bodywork and Aarisa Smith LMT 15732 liable in the event that a COVID infection occurs which may be traced back to this facility and interactions which took place there.

____ I will contact Bridgetown Bodywork and Aarisa Smith, LMT 15732 immediately to inform if I am diagnosed with COVID within 14 days after my session.

____ I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

____ Prior to every session, if any of the following apply, regardless of my vaccination status, I will contact the practitioner to cancel or reschedule. I will NOT come in and expose the practitioner, other clients and building occupants, and their families and associates to the risk of COVID in any of its variants.
(available for review at https://bridgetownbodywork.massagetherapy.com/covidqs)

- __ I have been asked to self isolate/quarantine by a doctor or public health official in the last 14 days
- __ I have received a positive COVID test result in the last 30 days
- __ I have experienced any cold or flu-like symptoms in the last 30 days (fever, cough, shortness of breath or other respiratory problem)
- __ I have had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flulike symptoms within the last 14 days
- __ I have experienced any of the following as a NEW PATTERN since the beginning of the pandemic and it has not resolved/been treated/established to not be COVID related by a medical professional
    - __ Fever(100.3°F or higher)
    - __ Chills or feeling feverish
    - __ Cough
    - __ Sore throat
    - __ Diarrhea, digestive upset
    - __ Nausea or vomiting
    - __ Nasal, sinus congestion or discharge
    - __ Loss of sense of taste or smell
    - __ Fatigue
    - __ Headache
    - __ Shortness of breath/Difficulty breathing
    - __ Sudden onset of muscle soreness (not related to a specific activity)
    - __ Rash or skin lesions (especially on the feet)
    - __ Any new discomfort with exertion or exercise?

____ I will follow all guidelines for safety as requested, which may include wearing a mask over both my mouth and nose for the duration of the session, and maintaining 6 feet of distance from other building occupants, and prepaying or bringing exact cash for appointments. Guidelines are evolving, and should I feel unable to follow these guidelines, I will not schedule a session with this practitioner. I understand that if I fail to properly wear a mask when requested, and have to be asked to correct this failure more than once, the session will be terminated, and no refund will be provided.

If you wish to reveal your vaccination status for the purpose of potentially having differing masking requirements from unvaccinated individuals, please show your vaccination card to the provider, and fill in
the dose dates and tracking information here:

____

____

Signature____Date_____________

Parent/Guardian Signature (If Under 18)_________________________Parent/Guardian Phone#__________

I understand that if I am in one of the categories or have any of the situations or conditions listed below I am at additional risk for severe and life threatening complications of COVID, as well as at potential risk for being more susceptible to incubating virus mutations and/or transmitting the virus to others, and am willing to assume the risk of interacting in this way. I further understand that depending on the professional recommendations at the time of any session, and my personal situation, I may be asked to wear a mask during the session for my safety and the safety of others, when other lower risk individuals may not be required to do so, and I agree to do this. (Please mark any categories which apply to you)

- ☐ Over the age of 65
- ☐ Member of a racial or ethnic minority
- ☐ Person with a disability
- ☐ Chosen to remain unvaccinated
- ☐ Cancer
- ☐ Organ/Blood Stem Cell/Bone Marrow transplant recipient
- ☐ Chronic Kidney Disease
- ☐ Chronic lung diseases, including COPD, asthma, interstitial lung disease, cystic fibrosis, & pulmonary hypertension
- ☐ Diabetes (Type I or Type II)
- ☐ Neurologic conditions or Dementia
- ☐ Down Syndrome
- ☐ Heart conditions (heart failure, coronary artery disease, cardiomyopathies or hypertension)
- ☐ HIV infection
- ☐ Immunocompromised state for any reason
- ☐ Prolonged use of corticosteroids
- ☐ Autoimmune conditions (including but not limited to Hashimoto's Graves, Lupus, Lyme disease, Rheumatoid arthritis - the list is too long to put here, but you know if this means you)
- ☐ Liver disease
- ☐ Obesity (I believe the medical system poorly understands the interaction between weight and health and tends to blame weight without investigating the true complexity of the situation, but this is on the official list of the CDC and I am including it here)
- ☐ Pregnancy
- ☐ Sickle cell disease or thalassemia
- ☐ Current or former SMOKER
- ☐ Stroke or cerebrovascular disease
- ☐ Substance use disorder, non-sober
- ☐ Other, unlisted high risk situation

TRAVEL:

Have you been in places with a high infection rate within the last two weeks/14 days (state designated "hotspots" or CDC travel risk designation of level 3 or higher)?
YES / NO

Have you traveled internationally or on an airplane in the past month?
YES / NO

____ I understand that if the answer to either of the above questions is yes for any given session, not limited to this one, that I may be asked to provide a virus test, or delay my session. This will depend on a variety of factors, including but not limited to the location of travel, duration of travel, protocols followed during the travel, potential exposures of the client, active variants and health organization recommendations, and practitioner discretion.

TESTING:

Have you been tested for COVID-19 in the last 30 days? **YES / NO**
If yes, what type of test did you have? **Rapid Antigen Home / Rapid Antigen at a Facility / PCR**

When was your most recent test? ______/______/_______
What were the results? **POSITIVE / NEGATIVE**

___I understand that if I have had a positive COVID test, that I must have been completely SYMPTOM FREE for a minimum of 14 days prior to having a session, but that I do not need to provide a negative test result.

____I declare that the information provided above is true and accurate to the best of my knowledge. I will immediately inform the therapist if there are any changes to my health status or consent.

Signature____Date_______________

Parent/Guardian Signature (If Under 18)______________________________Parent/Guardian Phone#_____________