



1347 McIntosh Avenue Broomfield, CO 80020 (720) 259-2289

In order to build a mutually respectful relationship Raining Faith Massage, Inc. has outlined its policies in regard to your massage therapy experience.

**Please read these statements carefully. If you agree with them, print out this page, sign it and bring it to your first visit.**

#### Appointments and Availability

You can reach Raining Faith Massage through a variety of ways. You may telephone and if there is no answer please leave a message. Your call will be returned no later than noon of the next business day. Please state when the best time to reach you is. You can also email Raining Faith Massage and those messages are checked daily as well. Appointments can be scheduled online at [www.rainingfaith.com](http://www.rainingfaith.com) You will then receive an email to confirm your appointment which will contain directions to my office.

#### Punctuality and Cancellations

Sessions begin at an appointed time and you may arrive up to five minutes before the session is to start. Sessions end sixty minutes from the appointed starting time. If you are late in arriving the session will begin if you are no more than twenty minutes late. However, the session will end at the appointed ending time and you will be charged for the full session. Conversely, in the event that Matthew is running late he will extend the session for the full hour or pro-rate the session, whichever you prefer. There is also a twenty-four hour cancellation policy. **Cancellations with less than twenty-four hours notice will be charged a \$35 cancellation fee.**

#### The Client/ Therapist Relationship

Our relationship is one of mutual respect as a client and therapist. Matthew does not date clients or develop sexually intimate relationships with his clients. The type of work that is offered is strictly therapeutic. If at any time you intend or attempt to make the session sexual in nature Matthew reserves the right to terminate the session immediately and full payment will be required.

#### Hygiene and Materials Used

Massage works best with a body that is clean and does not have any residual effects from perspiration due to exercise. Matthew will always do his best to be clean and without body odors or cologne. He appreciates the same from his clients. Cotton sheets are used that are changed and sanitized with each client. Matthew understands that some clients may be allergic to or see the potential for reactions to the sheets, cream or are sensitive to certain smells. If this is the case for you, please let him know in advance of the session. Alternatives to these products can be discussed and the room can be purified of any odors.

### Confidentiality

Your confidentiality is honored completely and it is understood that what happens during the session is between you and Matthew and not for anyone else to know. The only exception being that if Matthew were to be subpoenaed, (usually concerning health insurance cases), he is required by law to submit client charts and information. In regard to chance meetings in public between clients and Matthew, he makes it a point never to discuss the condition of the client. He will also not inquire as to how you are feeling in regard to any specific bodywork. Matthew leaves it up to you if you decide to initiate any conversation along the lines of your therapy. In that situation he is always open to answering any questions.

### Scope of Practice

It is not within the scope of practice to make a diagnosis, prescribe for specific conditions, or offer counseling. Raining Faith Massage has a complete referral network of health practitioners to refer clients to in the case of conditions that are beyond its capabilities and scope of practice.

### Intoxicants

Massage and bodywork can accelerate the use of intoxicants. It is recommended that you abstain from any alcohol for six hours prior to your massage. Any fluids taken following the session should be caffeine and alcohol free. Those that do not act as a diuretic and counter effect the work of the session. If you arrive under the influence of alcohol or any other intoxicants it is not safe to proceed with the massage. Forfeiture of the session and full payment will be requested at that time. Out of respect for you, Matthew will always be free of any intoxicants while he is working with you.

### Fees

The rate for a one-hour session is eighty-five dollars. If you desire a longer session please specify that when you schedule your appointment and your fee will be pro rated. Payment is required at time of services rendered. Payment is accepted in the form of cash, check or credit card. There will be a charge of twenty dollars for any returned checks.

I have read and understand the above outlined policies and any questions I have about them have been answered to my satisfaction. My signature indicates that I agree to the policies as stated above.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## **PERSONAL HEALTH HISTORY**

**Personal Data**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Referred by \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Health Care Provider \_\_\_\_\_ Phone \_\_\_\_\_  
Permission to consult with PCP? Please initial if yes. Yes \_\_\_\_\_ No \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ ID# \_\_\_\_\_

**Massage History/ Treatment Information**

Have you ever received a professional massage? \_\_\_\_\_ Date of last massage \_\_\_\_\_  
What results would you like to achieve from your sessions? \_\_\_\_\_

Prioritize the areas of your body that you would like to focus on \_\_\_\_\_

Please indicate with a check mark any areas that you **do not** wish to have massaged. Back \_\_\_ Legs \_\_\_ Buttocks \_\_\_ Arms \_\_\_ Abdomen \_\_\_  
Chest \_\_\_ Neck \_\_\_ Face \_\_\_ Feet \_\_\_ Other \_\_\_\_\_

Please list any activities that reduce stress in your life and the frequency. \_\_\_\_\_

**Health History**

Surgeries in the previous five years (please indicate date) \_\_\_\_\_

Surgeries more than five years ago \_\_\_\_\_

Describe injuries or accidents in the previous five years and the date of the injury \_\_\_\_\_

Injuries or accidents more than five years ago \_\_\_\_\_

Are you currently seeing your PCP for any reason and if so, why? \_\_\_\_\_

Please list any medications or supplements you are currently taking and the condition for which they are taken. \_\_\_\_\_

Please check any of the following conditions that you have experienced.

- |                          |                      |                      |
|--------------------------|----------------------|----------------------|
| <b>Musculoskeletal</b>   | <b>Circulatory</b>   | <b>Skin</b>          |
| ___ Fibromyalgia         | ___ Anemia           | ___ Boils            |
| ___ Rheumatoid Arthritis | ___ Thrombophlebitis | ___ Fungal Infection |
| ___ Osteoarthritis       | ___ Heart Disease    | ___ Herpes Simplex   |

- TMJ
- Sprains/Strains/Tendonitis
- Carpal Tunnel Syndrome
- Thoracic Outlet Syndrome
- Cramping/Spasms/Soreness

**Nervous System**

- Multiple Sclerosis
- Numbness/Tingling
- Headaches
- Stroke
- Seizure Disorders
- Sleep Disorders

**Other**

- Depression
- Sinusitis
- Allergies (please list)

- High or low BP
- Varicose Veins
- Diabetes
- Clotting Disorders

**Digestive**

- Constipation
- Gas/Bloating
- Diverticulitis
- Colitis
- Other \_\_\_\_\_

- Asthma
- Tuberculosis

- Warts
- Eczema
- Skin Cancer

**Reproductive**

- Breast Cancer
- Endometriosis
- PMS
- Prostrate Cancer
- Pregnancy? \_\_\_\_
- Other

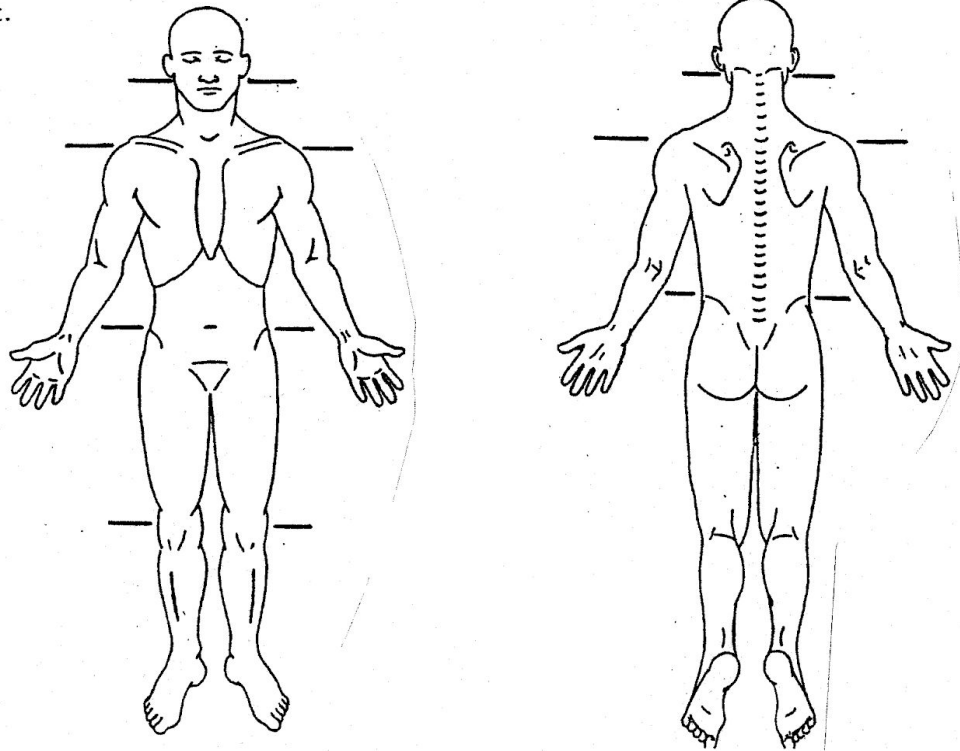
- Emphysema
- Chronic Fatigue

**Please indicate your use of the following**

	Light	Moderate	Heavy	None
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____

**Please list any concerns or any other information that you feel will help me to serve you better.** \_\_\_\_\_

On the figure below please indicate any area where you are currently experiencing pain and/ or discomfort.



It is my choice to receive massage therapy. 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 well-being 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 thrust 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 massage practitioner of any changes in my health status.

Signature \_\_\_\_\_ Date \_\_\_\_\_