Date:

Name: Email:

Occupation: Phone: ( )

DOB: Referred By:

Location of primary pain or concern:

Please list any history of accidents, injuries, operations/surgeries, and dates:

Please lis any medications or drugs you are currently taking:

If you answer yes to any of the following please explain in further detail.

Have you had a professional massage before?	☐ yes ☐ no	frequency:
Do you frequently suffer from stress?	☐ yes ☐ no	
Do you experience frequent headaches?	☐ yes ☐ no	How frequent:
Do you have diabetes?	☐ yes ☐ no	Type:
Have you consumed alcohol in the past 24 hours?	☐ yes ☐ no	
Do you have high blood pressure?	☐ yes ☐ no	
Do you suffer from epilepsy or seizures?	☐ yes ☐ no	
Do you have any contagious conditions?	☐ yes ☐ no	Type:
Do you have cardiac/circulatory problems?	☐ yes ☐ no	
Do you suffer from arthritis?	☐ yes ☐ no	Location:
Do you have seasonal allergies?	☐ yes ☐ no	
Other allergy concerns?	☐ yes ☐ no	Type:
Are you pregnant or nursing? If yes, please see back.	☐ yes ☐ no	Due Date:
Have you ever had cancer?	☐ yes ☐ no	Type:
Have you ever had Covid 19?	☐ yes ☐ no	Date:
Have you had the Covid 19 vaccine?	☐ yes ☐ no	Date:

Additional comments:

Covid 19

Please read, sign, and date the additional documents related to Covid 19.

Client Signature: _____ Date_____

Whom should I contact in case of an emergency?

Name: Relationship:

Phone: Email?

Healthcare provider:

Which hospital do you prefer in case of an emergency?

Please read carefully

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or technique may be adjusted to my leel of comfort. I further understand that massage should not be construed as a substitution for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and will be liable for payment of the scheduled appointment. The cancellation of any appointment must be done prior to 48 hours of the scheduled appointment or the client will be held responsible for 50% for that particular session. Cancellations made less than 48 hours of the scheduled appointment, including a no show will result in the full charge of the session.

Client Signature: _____ Date_____

Consent to treatment of minor: By my signiture, I hereby authorize *Kristen Breaux* to administer massage to my child or dependent as she may deem neccessary.

Child's name: Parent/Guardian Signature:

COVID-19 Health Information & Informed Consent

Name: _____ Date: _____

This document contains important information about your decision to receive massage services in light of the COVID-19 public health crisis. Please read and fill out this form carefully.

COVID-19 Information

Please anser these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100 F or above? ☐ Yes ☐ No
2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? ☐ Yes ☐ No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms? ☐ Yes ☐ No
4. Have you traveled anywhere outside of CA in the last two weeks? ☐ Yes ☐ No
   Location: _____
5. Have you had a new loss of sense of taste or smell? ☐ Yes ☐ No
6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐
7. Have you had a new onset of muscle aches and pain since the emergence of the virus? ☐ Yes ☐ No
8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? ☐ Yes ☐ No
9. Have you been tested for Covid-19? ☐ Yes ☐ No
10. Have you ever had Covid-19? ☐ Yes ☐ No Dates: _____
11. Have you had the Covid 19 vaccine? ☐ Yes ☐ No
12. Are you considered a higher risk for contracting Covid-19? ☐ Yes ☐ No

Conditions: _____

_____

Additional Comments:

_____

_____

_____

_____

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (initial in all places provided).

I understand that the novel Coronavirus (Covid-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that Covid-19 is extremely contagious and may be contracted from various sources. I understand Covid-19 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. To the best of their ability, my pracitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risk associated with the provision of health care during a pandemic. Given the current limitations of Covid-19 virus testing, I understand determining who is infected with Covid-19 is exceptionally difficult.

_____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of Covid-19 have been implemented. I undetstand that, because massage therapy work involves maintained touch and close physical proximity over and exteneded period of time in a closed space, there may be an elevated risk of disease transmission, including Covid-19. By signing this form, I acknowledge that I am aware of the risks involved and give my express permission and consent to receive massage and bodywork from this practitioner.

_____

I understand that to help prevent the spread of Covid-19 it is important to notify those I've been in contact with should I test positive for Covid-19. By signing this form I promise to notify the practioner if I test positive for Covid-19 at anytime within two weeks of my appointment. I give my consent for the practioner to notify anyone that may have been exposed to the office environment during that time while maintaining my anonymity. I give my consent for the practioner to notify professionals to aid with contact tracing should it be necessary. I also understand that in the event that someone else has tested positive for Covid-19 and has been in the office space within two weeks of my appointment that I will be contacted and notified.

_____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCES. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITIONS FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: Date:

Parent/Guardian Signature (for minor): Date:

Office Policies

One Within Wellness: Kristen D Breaux
916.768.0344 . onewithinwellness.com
3128 O st #6, Sacramento, CA 95816

Name: Date: DOB:

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Preparing for your appointment
Please fill out all paperwork in advance of your appointment. If you would like to fill out the information in person please arrive 15-20 minutes prior to your appointment. You may choose to fill out the intake form in your vehicle or in the waiting area. Please text when you arrive as the front door will remain locked at all times. Please wear a mask to your appointment. Masks will be required in the office and during appointments. If you do not have a mask I will provide one. If you have concerns about wearing a mask please contact me with details regarding your circumstances. Masks are required/recommended to protect all those spending time inside my office space.

Symptoms
For the health and safety of myself, office mates, clients, and others we may come in contact with please do not arrive for your appointment in person with any of these symptoms: fever, cough, sneeze, sore throat, or runny nose.

Massage/bodywork is not appropriate care for infectious or contagious illnesses. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period the cancellation fee may be waved.

Cancellation
Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule, especially if you are not feeling well, we understand and request for you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for cancellations at this time.
No show fees will still apply.

Tardiness
Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Client Signature: Date:

Parent/Guardian Signature (for minor): Date: