BODYWORK CARE CONSENT 2026

Thank you for choosing 5 Horizons Massage & Wellness. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions. All information will be held in the strictest of confidence.

Name_________________________________ Age____ DOB__________ M F Marital Status______ Phone__________________

Address____ City/State_______________________ Zip_____________

Email ____ Occupation____

Emergency Contact Name_____________________________________ Relation__________________ Phone__________________

Who referred you to us? ____ May we thank him/her? Y N

*I voluntarily consent to be treated with bodywork by Michelle Lee, LMT of 5 Horizons Massage & Wellness.

*I understand that the treatment I receive is provided for the basic purpose of relaxation and relief of muscular/soft tissue tension.

*Your therapist may recommend cupping which uses suction in glass cups applied to the body. Cupping removes muscle tension by increasing circulation to the area and may cause markings on the body resembling a bruise. These markings disappear over time, generally within a few days.

*I am not aware of any physical or mental health condition in my health that would be aggravated by bodywork. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. **Initial** _______

*I understand the treatment should not be construed as a substitute for a medical examination, diagnosis, or treatment and that massage and craniosacral therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session should be construed as such.

*I agree to update the therapist as to any changes in my medical profile during today's session and all future sessions and I understand that there shall be no liability on the therapist's part if I should fail to do so.

*I understand that I am entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

*I may seek a second opinion from another healthcare professional or may terminate therapy at any time.

*In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

*I understand that all practitioners at 5 Horizons Massage & Wellness and at Mountain Valley Chiropractic including Michelle Lee, LMT and Joseph Heinecke, DC, may participate in patient care meetings in which my care may be discussed.
Please initial for consent _____

*Your privacy is important to us. 5 Horizons Massage & Wellness follows the Health Insurance Portability and Accountability Act (HIPAA). You have the right to review our HIPAA guidelines upon request. At times you may wish to contact 5 Horizons Massage & Wellness via email, or vice versa, for communication which may contain protected health information. **Initial** _______

*I understand payment is due at the time of service and I agree to address any financial concerns prior to treatment. I understand that 5 Horizons Massage & Wellness accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment.
Initial _______

I have carefully read and I understand the above information. I am fully aware of what I am signing.

____ ________________________

Signature (Patient / Parent / Guardian) **Date**

Bodywork Symptom Survey

Name ____ Age _______ Date _____________

How would you rate your present state of health? Excellent ___ Good ___ Fair ___ Poor ___

Are you currently under a doctor's care? Y N If so, please explain: _____________________

____

Are you pregnant? Y N If so, how far along are you? ________________________________

Do you wear dentures? Y N

Have you had bodywork before? Y N

If so, which therapy and how often? ____

____

Reason for today's visit? ____

Describe any surgeries, accidents, or injuries you have had in the last three years? ___________

____

More than three years ago? ____

____

Do you have any chronic ongoing pain or stress? Y N Please explain: __________________

____

Please check any conditions that you have currently or have had in the past:

__ Allergies
__ Arthritis
__ Blood Clots
__ Breathing Problems
__ Diabetes
__ Fibromyalgia
__ Headaches
__ High/Low Blood Pressure
__ Hypermobility
__ Infectious Disease
__ Jaw Pain
__ Muscle/Joint Pain
__ Numbness/Tingling
__ Pregnant
__ Scoliosis
__ Sinus Problems
__ Skin Conditions
__ Tendonitis
__ Varicose Veins

Please describe these conditions: ____

____

Type of recreation and exercise: ____

____

List all medications you are currently taking: ____

____

____ _____________

Signature (Patient / Parent / Guardian) **Date**

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