Thyme for Wellness LLC
Amy S. Morin, CA, LMT

Medical History & Informed Consent

Today's Date: _____

Full Legal Name:_____ DOB: _____ Age: _____ M F

Address: _____ Tel. # _____

City, State, Zip: _____

Occupation: _____ Email address: _____

Medications/Allergies/History

Currently taking **ANY** medications: Y N

Blood pressure is: Low Normal High

Blood pressure is medicated: Y N

Currently taking blood thinners: Y N

Allergies: _____

Cancer related medications presently taking:

_____

_____

Other medications/supplements presently taking:

_____

_____

Pregnant: Y N Due Date: _____

Constipation: Y N

Physical trauma or accidents in the past year:

_____

Pain/Anxiety

Experiencing muscular or physical pain: Y N

Location: _____

Pain Scale: ___/10

Secondary to: _____

Pain Scale: ___/10

Secondary to: _____

Anxiety Scale: ___ /10

Secondary to: _____

Are you currently under a physician's care for an acute or chronic illness: Y N

If yes, please explain: _____

_____

_____

_____

Other health or medication conditions, such as heart condition, chronic pain, diabetes, blood clots, neuropathy, I should know about: _____

Oncology Diagnosis

Exact diagnosis & date: _____

_____

_____

_____

Blood Count

Blood counts: Low Normal High

White blood counts: Low Normal High

Platelets: Low Normal High

Lymph Nodes

Lymph node removal: Y N How many: _____

Location: _____

Heaviness or swelling in arm or leg: Y N

Chemotherapy

Receiving or have received chemotherapy: Y N

Chemo start date: _____

Chemo end date: _____

Most recent treatment: _____

Meta-port: Y N Location: _____

Experiencing neuropathy in hands and/or feet: Y N

Where: _____

Surgery

Oncology related surgeries: Y N

Date: _____

Location: _____

Reconstructive breast surgery: Y N

TRAM Flap Lat Flap Implants/Expanders

Other surgeries: Y N

Date: _____

Location: _____

_____

_____

Radiation

Receiving or have received radiation: Y N

Radiation start date: _____

Radiation end date: _____

Radiation location: _____

_____

Skin reaction to radiation: Y N

Describe: _____

_____

Emergency Contact Information	
Name: _____	Relationship: _____
Phone: C H W _____	Phone: C H W _____

Informed Consent

I understand that the massage given to me by Amy S. Morin, CA, LMT is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or comfort care.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes in my medical profile. I fully understand that there shall be no liability on the massage therapist part if I forget to do so.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the full scheduled appointment.

Should you need to cancel or reschedule, I agree to provide Amy S. Morin at least 24 hours in notice or Il will be financially responsible for the session time.

_____ _____

Client signature Date