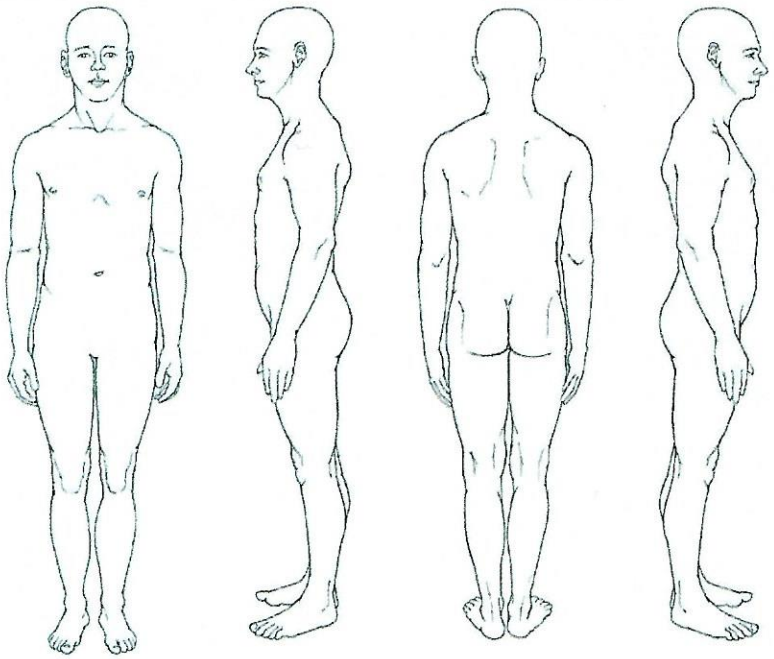
Patient Name: _____ **DOB:** _____

Circle areas of pain and/or symptoms



Please list any changes in your current health status including injuries, medications, surgeries, illness, etc:

_____

_____

_____

_____

I give my LMT permission to touch these areas today - Date: _____

Head/Scalp

_____I consent to have this area treated

_____I prefer Not to have this area touched

_____I consent to have this area undraped

_____I consent to treatment over clothes/sheet

Face/Jaw

_____I consent to have this area treated

_____I prefer Not to have this area touched

_____I consent to have this area undraped

_____I consent to treatment over clothes/sheet

Neck

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Shoulders

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Arms

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Hands

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Chest/Ribs

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Abdominal area

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Back

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Gluteal/Buttocks

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Pelvis/Sacrum/Pubic Bone

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Tailbone/Coccyx

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Hips/Legs

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Feet

_____I consent to have this area treated _____I prefer Not to have this area touched

_____I consent to have this area undraped _____I consent to treatment over clothes/sheet

Under current WA State Law I have previously signed a separate consent form for: Please circle:

~~Breasts/Nipples/Areolas~~ Yes NO ~~Breast area~~ Yes NO

~~Torso for males~~ Yes NO ~~Intraoral/inside of mouth~~ Yes NO

~~Perineal~~ Yes NO

I have received a copy of the consent form. _____ (initials)

_____

Print Patient Name & Guardian Name (if applicable)

_____ _____

Patient / Guardian Signature Date

_____

Print Massage Therapist Name

_____ _____

Massage Therapist Signature Date