

PLEASE PRINT (clearly)

Name: _____ Pronouns: They/them She/her He/him

Address: _____

City: _____ State: _____ Zip _____

Cell Phone: _____ Use TXT? No Yes UMASS employee ID: _____

E-mail: _____ Date of Birth: _____

How did you hear about The Healing ZONE? Internet, Facebook, Event, Friend: _____

Have you had Massage Therapy before? Yes () No () When? _____

Please list any **medications** you take regularly: _____

Are you involved in a regular exercise/ how often? _____

What is your activity level? _____

Do you have any medically related **restrictions**? No ____ Yes ____ Position restrictions?

Please explain _____

DO YOU HAVE ANY OF THE FOLLOWING? IF SO, PLEASE CHECK BOX to the LEFT:

<input type="checkbox"/>	Allergies (nuts, scents)	<input type="checkbox"/>	COVID-19 or Long COVID	<input type="checkbox"/>	Lymphedema Risk or History
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes (injection site)	<input type="checkbox"/>	Osteoporosis fragile bones
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Pacemaker / Port
<input type="checkbox"/>	Blood clots / History of DVT	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Pins or plates
<input type="checkbox"/>	Blood Pressure: ()High () Low	<input type="checkbox"/>	Headaches/how often?	<input type="checkbox"/>	Pregnancy _____ week Due date
<input type="checkbox"/>	Bruising tendency	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Sensitive Skin
<input type="checkbox"/>	Cancer-Type: Active treatment	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Swelling /Where?
<input type="checkbox"/>	Cancer-personal history Type: When:	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Varicose veins

Have you been vaccinated? Date: _____

- One Dose (Pfizer or Moderna)
- Both Doses (Pfizer or Moderna) -
2 weeks past 2nd shot

- Janssen Single Dose - 2 weeks past
- Not Vaccinated
- Boosted DATE : _____

Have you ever been diagnosed with COVID-19 (positive for or antigen test), received a presumed COVID-19 diagnosis or tested positive for COVID-19 antibodies?

yes

no

Describe any lingering effects: _____

Do you have any NEW challenges with exercise or getting your heart rate and respiratory rate up?

yes

no

Have you had a NEW onset of unexplained muscle aches and pain since the emergence of the virus? *

yes

no

Have you seen any NEW or unexplained marks, rashes, spots, bumps, or other lesions on your skin, fingers or toes?

yes

no

PLEASE NOTE: CANCELLATION POLICY ½ FEE FOR CANCELLATION WITHIN 24-HOUR and FULL FEE SAME DAY CANCELLATION. DUE TO COVID-19, ILLNESS RELATED CANCELLATIONS WILL NOT BE CHARGED ANY FEES. STAY WELL!

Please read and sign to indicate your content to receive massage at The Healing Zone:

It is my choice to receive massage or bodywork. I realize the treatment being given is for the purpose of stress reduction, relief from muscle tension, spasm or pain. I understand that therapists do not diagnose illness or prescribe medical treatment. I am responsible for consulting a PCP for any ailments I may have. I have stated all medical conditions and medications.

I understand that because massage involves touch and close physical proximity over an extended period of time there may be an elevated risk of disease transmission, including COVID-19. The therapist has explained the risks to me and I consent to receive a massage. I also consent to having my contact information shared with the relevant government authorities in the event that contact tracing is required.

Signature: _____

Date: _____
