

CONSENT FOR MASSAGE TREATMENTS

Client Name: _____ Age** _____ Date of birth: mm/dd/yyyy

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____
Home Cell Work Other Home Cell Work Other

How did you hear about us?

Emergency Contact: _____ Phone: _____ Relationship: _____

***IF under 18: Information of responsible adult*

Name: _____ Relationship To Client: _____

Contact Phone: _____ Signature/authorization _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Yes No Is this your first professional massage? Date of last Massage: _____

Allergic to: Latex Herbs Seasonal Foods Metal(s) Citrus

List any Medication allergies: _____ Other: _____

- Yes No Are you diabetic? Yes No Are you pregnant?
- Yes No Do you wear contact lenses? Yes No Do you have a pacemaker?
- Yes No Do you have any infectious disease(s)? Yes No Do you exercise regularly (2-3 times/ week)
- Yes No Do you have pain that radiates down your legs or arms?
- Yes No Have you taken any blood thinning products within the past 3 months?

OTHER MEDICAL INFORMATION

- Yes No Spinal problems Yes No Varicose veins Yes No Communicable diseases
- Yes No Chronic back pain Yes No Cancer Yes No Arthritis
- Yes No Frequent headaches Yes No Blood clots Yes No Skin Rashes
- Yes No Heart problems Yes No Sinus problems Yes No Fungus (*athletes foot, warts, etc*)
- Yes No High blood pressure

Please list or explain the following, if applicable:

Acute or chronic injury(s): _____ Surgeries: _____

Yes No Have you had Botox injections within the last 7 days?

Personal habits that may affect your well being: _____

I understand that massage therapy performed by a certified massage therapist is for the purpose of relaxation, stress reduction, relief from muscular tension or pain or increasing circulation. The massage therapist does not diagnose illness, disease, or any physical or mental disorder. The massage therapist does not prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. Massage therapy is not a substitute for medical examination, medical care, or diagnosis.

I have identified all of my known medical conditions and take personal responsibility to keep the massage therapist updated on my physical health. I understand any information provided by the therapist(s) is confidential and for educational purposes only. I do not need a doctor's release for any services provided.

Client Signature** _____ Date _____

Technician Signature _____ Date _____

*****If client is under 18- Signature of Responsible Adult Required*