



## Massage Therapy Consent Form

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City, State/Province \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

### General & Medical Information

Have you ever experienced a professional massage? \_\_\_\_\_

Which areas would you like to focus on during this massage? \_\_\_\_\_

Do you have any of the following conditions? If yes, please explain below as clearly as possible.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stress  | <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Contagious disease          |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Wear contact lenses            | <input type="checkbox"/> Back pain                   |
| <input type="checkbox"/> Pregnant  | <input type="checkbox"/> Cardiac/circulatory problems   | <input type="checkbox"/> Cancer                      |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Sensitive to touch or pressure | <input type="checkbox"/> Frequent headaches          |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Epilepsy or seizures           | <input type="checkbox"/> Bruise easily               |
| <input type="checkbox"/> Joint Swelling  | <input type="checkbox"/> Varicose veins                 | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Numbness or stabbing pains  |   | <input type="checkbox"/> Allergies to essential oils |
| <input type="checkbox"/> High Blood pressure. If yes, are you taking medication for this?          |   |  |
| <input type="checkbox"/> Surgery in the past five years?   |   |  |
| <input type="checkbox"/> Accident or suffered any injuries in the past 2 years? Broken bones, etc. |   |  |
| <input type="checkbox"/> Other medical conditions not listed.                                      |   |  |

Comments: \_\_\_\_\_

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Practitioner reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

**Reservation Policy:** Your card will be charged \$55 for any appointment missed or canceled without 48 hour notice

Credit card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Name on card: \_\_\_\_\_

**Client Signature** \_\_\_\_\_ Date \_\_\_\_\_