



Client Information & Consent Form for Massage. This form must be completed and signed before receiving a massage.

Name _____ Tel. No (h) _____ (w) _____ (c) _____

Address _____ Apt _____ City _____ State _____ Zip _____

DOB ___/___/___ Occupation _____ Email _____

Emergency Contact Name _____ Phone No _____ Relationship to You _____

Referred by _____

General & Medical Information

Have you ever experienced a professional massage? Yes No How recently? _____

Do you have any of the following conditions? If checked () , 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"/> Cancer | <input type="checkbox"/> Cardiac or circulatory problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Very sensitive to touch or press | <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?
Specify below | <input type="checkbox"/> Tension or soreness in a specific area?
Specify below | <input type="checkbox"/> High blood pressure?
If yes, taking medication for this? |
| <input type="checkbox"/> Surgery in the past five years?
Explain below | <input type="checkbox"/> Accident or any injuries in the past 2
years?
Explain below | <input type="checkbox"/> Other medical conditions not listed?
Explain below |

Comment _____

Are you taking any medications (prescribed or over the counter)? If so, please give details.

Past surgeries? Please give details and dates.

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 therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent. I give my permission to share information regarding my therapeutic massage treatment with my health care provider.

Client Signature _____ Date _____