



MASSAGE THERAPY

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Email Address \_\_\_\_\_ Gender: M F

How did you hear about us? \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Please indicate if you have any of the following conditions; certain medications and health problem may be contraindicated for massage. If necessary, a physicians release may be required from your primary care provider.

Table with 3 columns: Condition, Yes, No, Additional Information. Rows include Arthritis, Diabetes, Frequent Headaches, High Blood Pressure, Epilepsy or Seizures, Joint Swelling, Varicose Veins, Contagious Disease, Osteoporosis, Allergies, Back Pain, Knee Pain, Other Joint Pain, Surgery, Frequent Numbness or Tingling, Pregnant, Recent Injury, Allergy to Lotion or Oils.

Please list any medications you are currently taking \_\_\_\_\_

Please list any other medical conditions you may suffer from not listed above \_\_\_\_\_

Please Initial Below:

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 practitioner so that the pressure and or strokes may be adjusted to my level of comfort. \_\_\_\_\_

I understand that massage or bodywork should not be considered a substitute for medical care. \_\_\_\_\_

I agree to keep the practitioner updated on any changes in my medical profile and understand that there should be no liability on the practitioners' part if I fail to do so. \_\_\_\_\_

I understand that if I fail to give 24 hours notice of cancellation for my massage appointment I will be billed a fee of \$25.00. \_\_\_\_\_

I understand that any illicit or sexually aggressive remarks or advances made will result in immediate termination of the session and I will still be liable for payment of the scheduled appointment. \_\_\_\_\_

I affirm that I have stated all my known medical conditions and have answered all questions honestly.

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

Signature of Parent or Guardian (if under 18) \_\_\_\_\_ Date \_\_\_\_\_