CONSENT FOR TREATMENT

Massage Therapy Services

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE.

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.

_____ Stress	_____ Allergies	_____ Contagious disease
_____ Diabetes	_____ Wear contact lenses	_____ Back pain
_____ Pregnant	_____ Cancer	_____ Cardiac/circulatory problems
_____ Arthritis	_____ Sensitive to touch or pressure	_____ Frequent headaches
_____ Osteoporosis	_____ Epilepsy or seizures	_____ Bruise easily
_____ Joint swelling	_____ Varicose veins	_____ Depression

_____ Numbness or stabbing pains? Explain below.
_____ High blood pressure. If yes, are you taking medication for this? Explain below.
_____ Surgery in the past five years? Explain below.
_____ Accident or suffered any injuries in the past 2 years? Broken bones, etc. Explain below.
_____ Other medical conditions not listed. Explain below.

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 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.

_____ _____
Client Name (please print) Client Signature Date

Phone Number_____ Email:_____

_____ _____
Witness Name (please print) Witness Signature Date