MASSAGE INFORMED CONSENT FORM

FIRST:________________________________ MIDDLE:______________ LAST:_________________________________
BIRTHDATE:______/______/______ _____ FEMALE _____ MALE PHONE:______________________________
PHONE:____________________________
STREET:____ CITY:___________________ STATE:_______ ZIP:_________
EMAIL:____
EMERGENCY CONTACT:____ PHONE:______________________
HOW DID YOU HEAR ABOUT US? ____
REFERRED BY?____
OCCUPATION:__________________________________ HOBBIES:____
HOW WOULD YOU RATE YOUR OVERALL HEALTH? ___EXCELLENT ___VERY GOOD ___GOOD ___FAIR ___POOR
HAVE YOU HAD PREVIOUS MASSAGE? ___NO ___YES: RESULTS: ___EXCELLENT ___GOOD ___FAIR ___POOR
WHAT IS YOUR GOAL/CONCERN FOR TODAY'S SESSION?______________________________

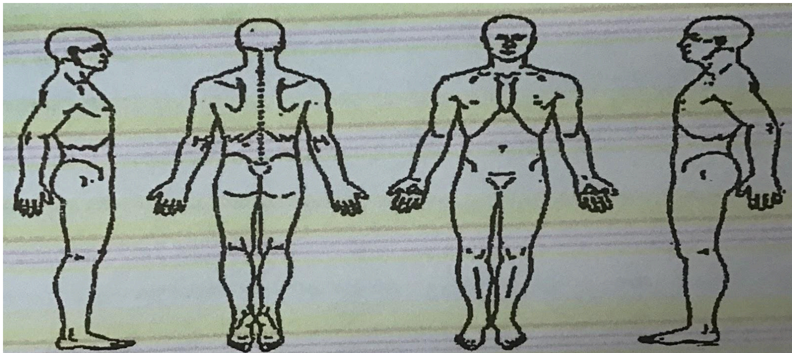
HERE IS A LIST OF THINGS MASSAGE CAN HELP WITH. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:

REDUCE STRESS AND ANXIETY   REDUCE MUSCLE SORENESS AND TENSION   IMPROVE CIRCULATION
IMPROVE IMMUNE FUNCTION   IMPROVE MOOD   REDUCE PAIN   SLEEP BETTER   INCREASE RELAXATION
IMPROVE FLEXIBILITY AND RANGE OF MOTION   LOWER HEART RATE AND BLOOD PRESSURE

WHAT KIND OF PRESSURE DO YOU PREFER? ___LIGHT ___MEDIUM ___FIRM
ARE YOU SENSITIVE TO TOUCH OR PRESSURE IN ANY AREA? ___NO ___YES: _________________________________
DO YOU EXPERIENCE ANY DIFFICULTY LYING EITHER ON YOUR FRONT OR YOUR BACK? ___YES FRONT ___YES BACK
ARE THERE CERTAIN STANDING OR SITTING POSITIONS YOU NEED TO AVOID OR THAT ARE PAINFUL OR UNCOMFORTABLE? ____NO ____YES: _________________
HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN? ____NO ____YES: ________
IS THERE ANY AREA WHERE YOU SEEM TO HOLD A LOT OF TENSION?_______________________________________
HAVE YOU EVER BEEN HOSPITALIZED? ___NO ___YES: ____
HAVE YOU HAD SIGNIFICANT FRACTURES, FALLS, AUTO ACCIDENTS, ETC.? ___NO ___YES: _______________________
ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITIONS? ___NO ___YES: ___________________________
LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION:

____

INDICATE ON THE DRAWINGS BELOW WHERE YOU HAVE PAIN/SYMPTOMS.



USING A SALE FROM 1-10 (10 BEING THE WORST), HOW WOULD YOU RATE YOUR PROBLEM?
0 1 2 3 4 5 6 7 8 9 10
IF YOU HAVE PAIN(S), HOW OFTEN DO YOU EXPERIENCE YOUR PAIN SYMPTOMS?
___CONSTANTLY (76-100% OF THE TIME) ___FREQUENTLY (51-75% OF THE TIME)
___OCCASIONALLY (26-50% OF THE TIME) ___INTERMITTENTLY (1-25% OF THE TIME)
HOW WOULD YOU DESCRIBE THE TYPE OF PAIN? ____
___SHOOTING ___NUMB ___DULL ___TINGLY
___SHARP WITH MOTION ___ACHY ___STIFF ___DIFFUSE ___SHARP ___BURNING
___STIFF ___STABBING WITH MOTION ___SHOOTING WITH MOTION ___ELECTRIC LIKE WITH MOTION
HOW ARE YOUR SYMPTOMS? ___GETTING WORSE ___STAYING THE SAME ___GETTING BETTER
DOES PAIN INTERFERE WORK? __NOT AT ALL __A LITTLE BIT __MODERATELY __QUITE A BIT __EXTREMELY
DOES PAIN INTERFERE WITH ACTIVITIES? __NO ___LITTLE BIT ___MODERATELY ___QUITE __EXTREMELY
DO YOU CONSIDER THIS PROBLEM TO BE SEVERE? __YES __YES, AT TIMES __NO
HOW LONG HAVE YOU HAD THIS PROBLEM?____
HOW DO YOU THINK YOUR PROBLEM BEGAN?____
WHAT AGGRAVATES YOUR PROBLEM?____
WHAT HELPS YOUR PROBLEM?____

	YES PAST	NOW	NO
Pregnancy	___	___	___
Headaches	___	___	___
Neck Pain	___	___	___
Whiplash	___	___	___
Upper Back Pain	___	___	___
Mid Back Pain	___	___	___
Low Back Pain	___	___	___
Herniated Disc	___	___	___
Shoulder Pain	___	___	___
Elbow/Upper Arm Pain	___	___	___
Wrist Pain	___	___	___
Hand Pain	___	___	___
Hip Pain	___	___	___
Upper Leg pain	___	___	___
Knee Pain	___	___	___
Ankle/Foot Pain	___	___	___
Jaw Pain	___	___	___
Whiplash	___	___	___
Joint Pain/Stiffness	___	___	___
Arthritis	___	___	___
ALS	___	___	___
Parkinson's	___	___	___
Multiple Sclerosis	___	___	___
Neuritis/Neuralgia	___	___	___
Fibrositis	___	___	___
Rheumatoid Arthritis	___	___	___
Cancer	___	___	___
Autoimmune Disease	___	___	___
Osteoporosis	___	___	___
Orthopedic Pins/Plates	___	___	___
Tumor, Cysts, Lipomas	___	___	___
Asthma/Breathing Problems	___	___	___
Pneumonia	___	___	___
Chronic Sinusitis	___	___	___
Heart Problems	___	___	___
High Blood Pressure	___	___	___
Low Blood Pressure	___	___	___
Heart Attack	___	___	___
Chest Pains	___	___	___
Stroke	___	___	___
Peripheral Artery Disease	___	___	___
Blood Clots, Phleboliths	___	___	___
Hemophilia	___	___	___
Varicose/Spider Veins	___	___	___
Bad Circulation	___	___	___
Gout	___	___	___
Pregnant	___	___	___

	YES PAST	NOW	NO
Anemia	___	___	___
Raynaud's	___	___	___
Easy Bruising	___	___	___
Angina	___	___	___
Kidney Stones	___	___	___
Kidney Disorders	___	___	___
Bladder Infection	___	___	___
Painful Urination	___	___	___
Loss of Bladder	___	___	___
Frequent Urination	___	___	___
Abdominal Pain	___	___	___
Irritable Bowel Syndrome	___	___	___
Abnormal Weight Gain	___	___	___
Abnormal Weight Loss	___	___	___
Loss of Appetite	___	___	___
Crohn's	___	___	___
Hernia	___	___	___
Ulcer	___	___	___
Hepatitis	___	___	___
Liver/Gall Bladder Disorder	___	___	___
General Fatigue	___	___	___
High Stress/Anxiety	___	___	___
Panic Attacks	___	___	___
Fibromyalgia	___	___	___
Hypothyroidism	___	___	___
Hyperthyroidism	___	___	___
Endocrine Disorders	___	___	___
Muscular Incoordination	___	___	___
Visual Disturbances	___	___	___
Dizziness	___	___	___
Diabetes	___	___	___
Excessive Thirst	___	___	___
Poor Sleep / Insomnia	___	___	___
Tinnitus, Ear Ringing	___	___	___
Prostate Problems	___	___	___
Smoking / Tobacco Use	___	___	___
Drug / Alcohol Dependence	___	___	___
Allergies	___	___	___
Depression	___	___	___
Grieving	___	___	___
Systemic Lupus	___	___	___
Epilepsy	___	___	___
Dermatitis/Eczema/Rash	___	___	___
HIV/AIDS	___	___	___
Rash	___	___	___
Osteoarthritis	___	___	___
Other Conditions:	___	___	___

PLEASE READ AND INITIAL BEFORE EACH STATEMENT.

___CANCELLATIONS/RESCHEDULES MUST BE MADE NO LESS THAN 24 HOURS OR WILL BE FULLY CHARGED.

___IF LATE, THE SESSION WILL END AT THE APPOINTED TIME.

___MASSAGE THERAPY IS FOR THE PURPOSE OF STRESS REDUCTION, RELIEF FROM MUSCLE TENSION OR SPASM, OR FOR INCREASING CIRCULATION AND ENERGY FLOW. I WILL INFORM MY MASSAGE THERAPIST IF I FEEL DISCOMFORT.

___I UNDERSTAND THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE, OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MASSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMACEUTICALS, NOR DO THEY PERFORM ANY SPINAL MANIPULATIONS. IT HAS BEEN MADE VERY CLEAR TO ME THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS AND/OR DIAGNOSIS AND THAT IT IS RECOMMENDED THAT I SEE A PHYSICIAN FOR ANY AILMENTS THAT I HAVE.

___I HAVE STATED ALL KNOWN MEDICAL CONDITIONS AND WILL UPDATE THE THERAPIST ON MY PHYSICAL HEALTH.

___I UNDERSTAND AND AGREE THAT I AM RECEIVING MASSAGE THERAPY ENTIRELY AT MY OWN RISK. IN THE EVENT THAT I BECOME INJURED EITHER DIRECTLY OR INDIRECTLY AS A RESULT, IN WHOLE OR IN PART, OF THE AFORESAID MASSAGE THERAPY, I HEREBY HOLD HARMLESS ALL CLAIMS AND LIABILITY WHATSOEVER.

___MASSAGE GIVEN HERE IS THERAPEUTIC. ANY SEXUALIZATION ATTEMPT WILL NOT BE TOLERATED AND IS GROUNDS FOR TERMINATION OF THE MASSAGE AND I WILL BE LIABLE FOR PAYMENT OF THE SCHEDULED APPOINTMENT.

______________________________ ______________

CLIENT SIGNATURE DATE

CONSENT TO TREATMENT OF MINOR: I HEREBY AUTHORIZE MASSAGE AND BODYWORK TECHNIQUES FOR MY CHILD.

______________________________ ______________

SIGNATURE OF PARENT OR GUARDIAN DATE