

Informed Consent for Massage

(Please have client complete for your records)

Name: _____ Phone: _____ Date: _____

Background: Have you ever had a massage? _____

Medical: Are you currently or within the last year under a doctor's care? _____

Health Problems: (Check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Heart | <input type="checkbox"/> Suffer from Stress |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Skin Disorder | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizure | |

-
- | | | | |
|----------------------------------|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Tension | <input type="checkbox"/> Soreness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Stabbing Pain |
|----------------------------------|-----------------------------------|-----------------------------------|--|

If so, where? _____

Surgeries or injuries in the past tow (2) years? _____ Sensitive to touch or pressure anywhere _____

Do you have any medical conditions I should be aware of? _____

What type of massage would you like?

- | | | | |
|--------------------------------------|--|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Deep Tissue | <input type="checkbox"/> Injury Specific | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Sports |
|--------------------------------------|--|-------------------------------------|---------------------------------|

What kind of massage would you like?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Full Body | <input type="checkbox"/> Specific Area |
|------------------------------------|--|

What kind of pressure would you like? _____

What areas do you want focused on? _____

***Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/body work may contraindicate. Referral from your primary care physician may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that massage/bodywork practitioners 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/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ **Date:** _____

(If under 18 years of age, this should be signed by a parent or guardian)

Parent/Guardian Signature: _____ **Date:** _____