The Wellness Center
OF WEST MICHIGAN

Massage Therapy Registration

Patient Information

1. **Name (Last, First MI):** _____
2. **Address:** _____
   City State Zip
3. **Cell Number:** _____ **Cell Provider:** _____
4. **Email:** _____
5. **Date of Birth:** _____/_____/ _____
6. **Gender (circle one):** Male / Female / Other_____
7. **Emergency Contact:** _____ **Number:** _____
8. **How did you find us? (circle one):** Internet / MVP / _____
9. **Whom may we thank for referring you?** _____

Questions

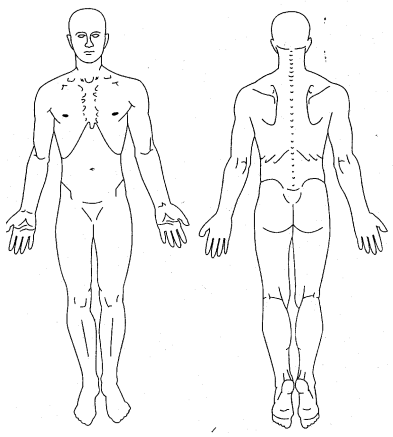
Please answer the following questions by circling the appropriate answer.

Please explain any YES answer below.

Y N Have you ever had a professional massage?
Y N Have you ever had surgery?
Y N Do you have spinal problems?
Y N Are you pregnant?
Y N Do you have any skin problems or allergies?
Y N Do you wear contact lenses or dentures?
Y N Do you take any prescribed medications?
Y N Do you have chronic back pain?
Y N Do you have frequent headaches?
Y N Pain which radiates down legs or arms?
Y N Are you constantly tired?
Y N Do you suffer from tension?
Y N Do you have any heart problems?
Y N Do you have high blood pressure?
Y N Do you have varicose veins?
Y N Do you have blood clots?
Y N Have you ever had cancer?
Y N Do you have arthritis?
Y N Have you ever suffered any acute injury?
Y N Do you have athlete's foot or plantars warts?

Condition and Reason for Visit

1. **Reason For Visit:** _____
2. **Use Body Diagram:** Circle the Main Areas you would like massaged
3. **Circle the Range of Pressure you like:**
   (Deep) 5 4 3 2 1 (Light)
4. **Circle the Technique(s) you would like:**
   Long Gliding Kneading Trigger Point
   Stretches Vibration Instrument
   Other: _____
5. **Do you want Full Body Massage: Yes / No**
6. **Level of Conversation / Education you're comfortable with today:**
   None Some I want to learn I'm a Talker



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Massage Consent Form

I, _____, understand that massage therapy given is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used can be adjusted to my comfort level.

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 this massage therapy is not a substitute for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and TAKE IT UPON MYSELF to keep the massage therapist updated on my physical health.

SIGNATURE:_____DATE: ___/___/___

Consent to Treat a Minor

I _____ parent/guardian of _____ have read and understood the statements regarding massage therapy. By my signature, I authorize The Wellness Center of West Michigan massage therapist to provide massage treatments bodywork to my child or dependent.

Signature of Custodial Parent or Guardian **Date**

_____ _____