AURA STUDIO

Massage Consultation Form

CLIENT INFORMATION

Name | D.O.B.

Address

City | State | Zip Code

Phone | Occupation

Email

Emergency Contact | Phone

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

If yes, when? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

Details _____

Have you had any orthopedic injuries? ☐ Yes ☐ No

Details _____

Do you have any difficulty lying on your front, back or side? ☐ Yes ☐ No

Details _____

Are you currently pregnant? ☐ Yes ☐ No

Due Date: _____

Do you currently see a Chiropractor? ☐ Yes ☐ No

If yes, how often? _____

Do you sit for long periods at a computer, work or driving? ☐ Yes ☐ No

What type of massage do you require?

☐ Relaxation ☐ Therapeutic/Deep Tissue ☐ Other _____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Do you have any of the following? ☐ Dentures ☐ Prosthetics

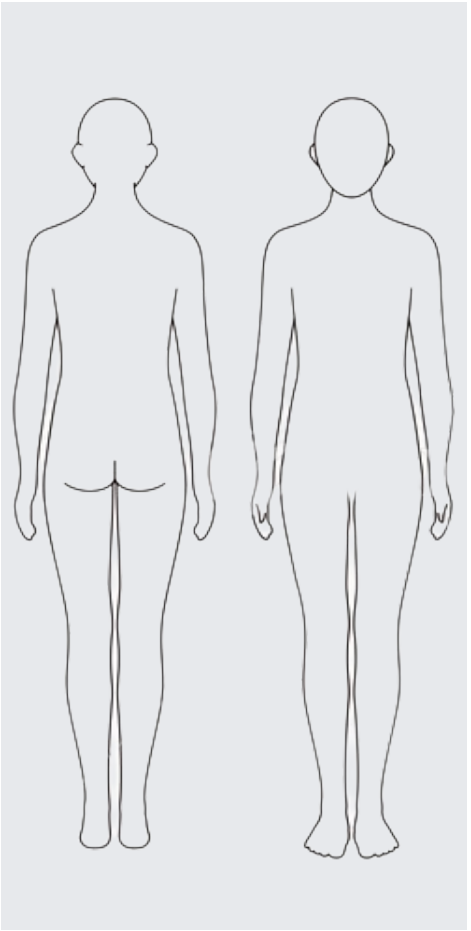
☐ Sensitive Skin ☐ Contact Lenses ☐ Hearing Aids

What are your goals for this treatment session?

Details _____

AREAS OF CONCERN

Please mark any that apply



MEDICAL HISTORY (Please check all that apply)

☐ Anxiety	☐ Easy Bruising	☐ Hives/Shingles	☐ Pins/Plates	☐ Sinusitis
☐ Arthritis	☐ Emphysema	☐ Hormone Therapy	☐ Poor Circulation	☐ Smoker
☐ Asthma	☐ Epilepsy	☐ Infectious Skin Condition	☐ Pre-Cancerous Lesions	☐ Spinal Problems
☐ Bronchitis	☐ Fatigue	☐ Jaw Pain (TMJ)	☐ Psoriasis	☐ Stress
☐ Bursitis	☐ Fibromyalgia	☐ Joint/Muscle Pain	☐ Rashes	☐ Tendonitis
☐ Cancer	☐ Headaches/ Migraines	☐ Loss of Sensation	☐ Recent Surgery	☐ Transplant/s
☐ Cardiovascular Issues	☐ Heart/Liver/ Kidney Diease	☐ Low Blood Pressure	☐ Respiratory Condition	☐ Tuberculosis
☐ Chronic Fatigue	☐ Hemophilia	☐ Lyme Disease	☐ Sciatica	☐ Varicose Veins
☐ Congestive Heart Failure	☐ Hepatitis	☐ Multiple Sclerosis	☐ Seborrhea	☐ Warts
☐ Depression	☐ Hernia	☐ Muscle Cramps	☐ Seizures	☐ Other
☐ Diabetes	☐ Herpes Simplex	☐ Osteoporosis	☐ Sensory Loss	_____
☐ Digestive Issues	☐ High Blood Pressure	☐ Pacemaker	☐ Skin Cancer	_____
☐ Dislocations	☐ HIV	☐ Phlebitis	☐ Shortness of Breath	_____

Are you currently taking any medications, including oral, topical or transdermal? ☐ Yes ☐ No

Details

Do you have any allergies or sensitivities to oils, lotions, ointments, fruits or nuts? ☐ Yes ☐ No

Details

By signing below, I agree to the following:

The information I have provided regarding my medical history is accurate to the best of my knowledge. I understand that massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that I see a physician for any physical ailment that I may have. I understand that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services. I understand that the therapist does not prescribe medical treatments or pharmaceuticals and does not perform any spinal adjustments.

I understand that the therapist shall drape the breasts of all female clients and not engage in breasts massage of female clients unless the client gives written consent before each session involving breast massage.

I understand that draping of the genital area and gluteal cleavage will be used at all times during the session.

I understand that if I am uncomfortable for any reason, I may ask the therapist to end the massage, and the therapist will end the massage. The therapist also has the right to end the session if uncomfortable for any reason.

I agree to waive all liability towards the massage therapist and Aura Studio DFW for any injury or damages incurred due to my failure to disclose any existing or past health conditions.

Date:

Client Signature

Therapist Signature