



# Massage Consent Form

*This questionnaire must be complete to receive a free massage*

Name	Date of Birth
Phone	Email
Type of Work/Profession	City
Do you have health insurance? YES/NO	Employer

*Please Indicate below if you suffer from any of the following health concerns:*

- Headaches/Migraines
- Wrist/Hand Pain
- Leg or Hip Pain
- Neck Pain
- Tingling/Numbness Arms/Hands
- Ankle/Foot Pain
- Pain between Shoulder Blades
- Carpal Tunnel
- Tingling/Numbness Legs/Feet
- Tension Across Shoulders
- Mid-Back Pain
- Dizziness
- Shoulder or Arm Pain
- Low-Back Pain
- Problems Sleeping
- Sciatic Pain
- Asthma

Which of these issues have you experienced for the longest time?

Are you currently receiving treatment for these ailments? YES/NO

*MedSpa Therapy LLC is not liable for any pre-existing injury, or aggravation of such injury, that has or has not been communicated to the practioner prior to the massage.*

Signature \_\_\_\_\_ Date \_\_\_\_\_ 20\_\_