



Massage Consent Form

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_ City \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Have you ever received massage therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list name and reason for medications \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing a healthcare professional? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list names and reason/treatment \_\_\_\_\_

\_\_\_\_\_

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- |   |  |
|---|--|
| <input type="checkbox"/> arthritis                  | <input type="checkbox"/> depression, panic disorder, other psych condition |
| <input type="checkbox"/> diabetes                   | <input type="checkbox"/> diverticulitis                                    |
| <input type="checkbox"/> blood clots                | <input type="checkbox"/> headaches   |
| <input type="checkbox"/> broken/dislocated bones    | <input type="checkbox"/> heart conditions                                  |
| <input type="checkbox"/> bruise easily              | <input type="checkbox"/> back problems                                     |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> high blood pressure                               |
| <input type="checkbox"/> chronic                    | <input type="checkbox"/> insomnia  |
| <input type="checkbox"/> pain                       | <input type="checkbox"/> muscle strain/sprain                              |
| <input type="checkbox"/> constipation/diarrhea      | <input type="checkbox"/> pregnancy   |
| <input type="checkbox"/> auto-immune condition*     | <input type="checkbox"/> scoliosis   |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> seizures  |
| <input type="checkbox"/> skin conditions            | <input type="checkbox"/> whiplash  |
| <input type="checkbox"/> stroke                     | <input type="checkbox"/> chemical dependency (alcohol, drugs)              |
| <input type="checkbox"/> surgery                    |  |

(\*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so: \_\_\_\_\_

\_\_\_\_\_

Do you have any of the following today:

skin rash     cold/flu     open cuts     severe pain  
 anything contagious     injuries/bruises

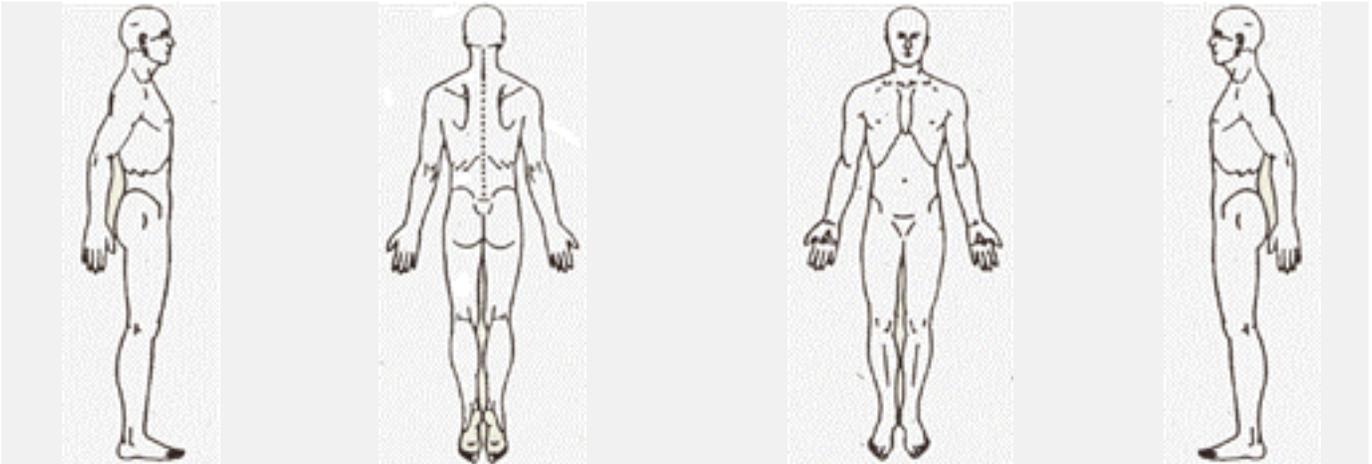
Do you have any allergies to:

medications     foods (nuts, etc.)  
 environmental allergens (dust, pollen, fragrances)  
 reactions to skin care products

If any of the above are checked, please give details: \_\_\_\_\_

Are you wearing:     contact lenses     hearing aid     hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? \_\_\_\_\_

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:  
 vsighing, yawning, change in breathing v stomach gurgling v emotional feelings and/or expression movement of intestinal gas v energy shifts v falling asleep v memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session immediately and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: \_\_\_\_\_ Date \_\_\_\_\_



## **Massage Therapy Missed Appointment Policy**

Our office strives to provide top-notch quality massage therapy in a timely manner. Pure Radiance Day Spa missed appointment policy is as follows. No missed appointment fee will be applied if we are notified at least 24 hours prior to an appointment. A missed appointment fee will apply for all all appointments with less than 24 hours or no call, no show. These appointments will be charged for the full cost of the appointment. If you are late for your appointment, your appointment will be deducted by that amount of time in order for us to stay on schedule. We ask that you extend common courtesy to our spa, massage therapist and other guests who may wish to schedule during that time.

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Name

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Date