



Massage Consent Form

Name _____ Date of birth _____

Address _____

State _____ City _____ Home Phone _____

Work 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

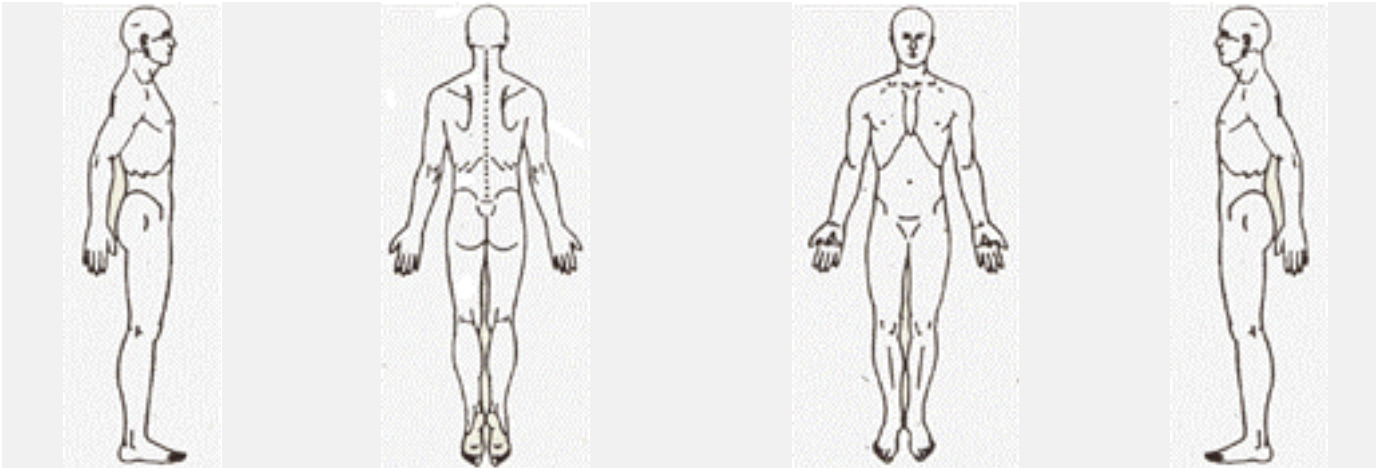
Do you have any allergies to:

_____ 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 \$35 missed appointment fee will apply for 1-hour massages. A \$20 missed appointment fee will apply for 30-minute massages. Our office asks that you extend common courtesy to our office, massage therapist and other patient's who may wish to schedule during that time.

Name

Date