



Name_____Birth Date_____

Address_____

City_____State_____Zip_____

Phone_____Text notifications Y N

Email_____

Would you like to receive newsletters and other promotions via email? Y N

Occupation_____

How did you hear about us?_____

Have you had massage therapy before? Y N

What is your major area of pain or concern?_____

When did you first notice it?_____

What brought it on?_____

Is it getting better or worse?_____

What makes it better?_____

What makes it worse?_____

Does it interfere with: Work?_____Sleep?_____Recreation?_____

Pain level right now? Less pain 1 2 3 4 5 6 7 8 9 10 more pain

Are you pregnant?_____Month?_____Problems_____

Circle any of the following you are currently experiencing.

Fever	COVID symptoms	Cancer/ Cancer History
Infections	Broken Bone	History of Blood Clots
Contagious Conditions	Systemic Swelling	Removed, Tested or
Post Surgery	Idiopathic Edema	radiated lymph node
Currently Sick	Renal Failure	
Other Health		
Problems		

What are your goals for your massage session?_____

What kind of pressure do you like?_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Understanding all of this, I give my consent to receive care.

Signature_____Date_____