Consent for Treatment-The Massage Studio

Name: _____ Date:_____Date of Birth: _____

Address: _____ City: _____

State: _____ ZIP: _____

Phone Number: (home) _____ (cell) _____

Email Address: _____

Would you like to receive occasional email confirmations, reminders or updates? Yes No
Please note that failure to keep your appointment or cancel within 24 hours may result in additional fees. See Policies for details.

How did you hear about us?: _____

Have you ever received a professional facial or massage therapy session? Yes No

How recently? _____

What type of pressure do you prefer? Light Medium Firm Deep Unsure

The following required information must be completed in its entirety, honestly and to the best of your knowledge:
Are you pregnant? No Yes: How far along? _____
Please list all medications (over-the-counter and prescribed) and supplements that you are currently

taking: _____

_____
Please list all allergies or sensitivities, <u>including scents/smells</u>:

_____

_____
Do you have or have you recently been in contact with any contagious illnesses or infections, including skin conditions: No
Yes, please explain:_____

Have you ingested any alcohol or anti-inflammatory medication in the last 24 hours? _____
What is your typical daily intake of water? None Light Moderate
Heavy Caffeine? None Light Moderate
Do you smoke? Yes No
<u>PLEASE DO NOT SMOKE PRIOR TO YOUR TREATMENT. I am highly sensitive to cigarettes and this tends to be a trigger for migraines. Thank you.</u>
<u>Please circle any health condition below that applies to you now or in the past 6 months:</u>

Anemia	Cancer	HIV/Aids	Surgery	Anxiety/Panic Attacks
Cardiac Problems	Jaw Pain	Varicose Veins	Arthritis	Circulatory Problems
Knee Pain	Arm/Elbow/Wrist Pain		Asthma	Claustrophobia
Low Blood Pressure	Constipation	Migraines	Back Pain	Diabetes
Neck/Shoulder Pain	Blood clots	Fainting	Gout	Numbness or Tingling
Heart Attack	Fibromyalgia	PTSD	Bone Disease	Sciatica
Broken Bones	Headaches	Scoliosis	Bruising	Seizures
Bursitis Hip/leg pain	Stroke	High or Low Blood Pressure		

Further explanation for any of the above conditions:

_____

_____

For MASSAGE therapy, indicate any areas of pain, discomfort, or tightness. For SKINCARE treatments, list concerns and what you hope to accomplish with your facial service.
*Please list any areas that are highly sensitive/ticklish/or you would prefer to AVOID (face, feet, scalp, etc)

_____

_____

_____

By providing my signature below, I confirm that the information recorded above is complete, accurate, and honest to the best of my knowledge. I understand that massage therapy is not a replacement for medical treatment, and that the therapist may only perform treatments within his or her scope of practice and level of comfort. Anything said during this session shall not be regarded as medical advice, treatment, diagnosis, or prescription.
I understand that the therapist may refuse service at any time for any reason, and that certain medical issues may be a contraindication for massage therapy services and will be referred to a medical professional.
It is my choice to receive spa therapies. I understand that it is my responsibility to inform the massage therapist of any changes to my medical health profile and that the therapist will not be held liable for anything resulting from my failure to do so.
I agree that I have been given sufficient opportunity to ask questions and make specific requests in order to make my treatment time as comfortable as possible. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.
I understand that any illicit or sexually suggestive behavior, remarks or advances made will result in the immediate termination of the session and I will be liable for payment of the scheduled service.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____