Massage Consent Form

Name _____ Date of Birth _____

Address _____ City _____

State _____ ZIP _____ Phone (H) _____ Phone (W/C) _____

Occupation _____ Referred By _____

Emergency Contact _____ Phone _____

Physician _____ Chiropractor _____

Sports/Physical Activities _____

Current Medications/OTC/Supplements _____

Email Address _____

Please answer the following to the best of your knowledge:

1. Have you had a professional massage before? ___ Yes ___ No
2. Do you have allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts? ___ Yes ___ No
3. Is there a particular area of your body in which you are experiencing tension, stiffness, or other discomfort? ___ Yes ___ No If yes, please describe _____
4. Do you have any particular goals for this massage session? _____
5. If you are currently under medical supervision, please explain _____
6. Please list any accidents or operations _____
7. Please check any condition/symptom listed below that applies to you:

- ☐ Allergies (any & all)
- ☐ Atherosclerosis
- ☐ Athlete's Foot/Fungal Infection
- ☐ Artificial Joint
- ☐ Cancer/Tumors
- ☐ Circulatory Disorder
- ☐ Cold Sore/Herpes
- ☐ Contact Lenses
- ☐ Decreased Sensation
- ☐ Dentures
- ☐ Diabetes, Type I or Type II
- ☐ Difficulty Lying on back, front or side
- ☐ Digestive Problems
- ☐ Easy Bruising
- ☐ Epilepsy
- ☐ Fibromyalgia or CFS
- ☐ Fractures
- ☐ Headaches
- ☐ Hearing Aid
- ☐ Heart Condition
- ☐ High or Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Joint Disorder
- ☐ Lice or Scabies
- ☐ Lung or Breathing Problems
- ☐ Open Sores or Wounds
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pregnancy – If so, how far along ___
- ☐ Psoriasis
- ☐ Rash/Eczema
- ☐ Recent Accident or Injury
- ☐ Recent Surgery
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Scleroderma
- ☐ Spinal Problems
- ☐ Stroke or Blood Clots
- ☐ Swollen Glands
- ☐ Ulcers
- ☐ Varicose Veins

8. Anything else about your massage therapist should know before planning your massage session?

_____

I _____, understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a massage therapist will never touch genitals, breast tissue, or any other area I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problems. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medication in the future.

Signature _____ Date _____