



CLIENT INFORMATION

Name: _____ Date: _____

E-Mail: _____ Date of Birth: _____

How did you hear about us? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Emergency contact _____ Phone _____

Please circle any that apply: Pain/Tightness in SHOULDER: RIGHT LEFT

Pain/Tightness in NECK: RIGHT LEFT

Pain/Tightness in LOW BACK

Pain/Tightness ARM: RIGHT LEFT LEGS: RIGHT LEFT

Please check if you have or have had any of the following:

AIDS/HIV _____ Epilepsy _____ Pacemaker _____ Parkinson's Disease _____ Migraine Headaches _____

Diverticulitis _____ Fractures _____ Anemia _____ Arthritis _____ Asthma _____ Bleeding Disorder _____

Cancer _____ Diabetes _____ Heart Disease _____ Hepatitis _____ Hernia _____ Herniated Disc _____

Herpes _____ High Cholesterol _____ Kidney Disease _____ Liver Disease _____ Osteoporosis _____

Pinched Nerve _____ Varicose Veins _____ Seizures _____ Fibromyalgia _____ Fever _____

High Blood Pressure _____ Low Blood Pressure _____ Sciatica _____ Seizures _____ Skin Condition _____

Headaches _____ Other _____

ALLERGIES (Please circle all allergies):

Almond Camphor Citrus Coconut Eucalyptus Lanolin Lavender Menthol Nut
Oils Peppermint Soy Other: _____

Please check or describe any interest in other wellness services we offer:

Massage Therapy ____ Weight Loss ____ Body Slimming ____ Fat Reduction ____ Cellulite Reduction ____
Facials ____ Microdermabrasion ____ Botox/Dermal Fillers ____ Chemical Peels ____ Skincare Products ____
Hormone Therapy ____ Anti-Aging Medicine ____ Sclerotherapy (Spider Vein Treatment) ____
Other: _____

Informed Consent

I hereby consent to my my Therapist to provide me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided and disclosed all of those medical conditions affecting me. It is my responsibility to keep the wellness studio and therapists updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time. I understand that at any time I may withdraw my consent and treatment will be stopped.

Signature of Client

Date

Witness

Date