Massage Therapy Consent Form

Please read carefully and sign before receiving therapy. All information provided is confidential and will not be given out to anyone.

I understand that the massage I receive is provided for the purpose of relaxation and/or relief of muscular tension. If I experience any discomfort during the session, I will immediately inform the therapist so that the pressure and strokes may be adjust. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that Irmina Polit is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse or terminate massage session to anyone whom she considers to have a condition for which massage is contraindicated.

Client's Name……

Therapist Name ……Irmina Polit……

Client's Personal Details:

Name ……

Address ……..

……

Referred by……

DOB ……

Home Tel. No ……

Alternate Tel. No……

Occupation……

Weight…… Height……

E-mail address……..

Emergency contact information:

Name……

Relationship……Phone……

Physician Name……

Reason for visit……

Have you ever had a professional massage or other therapy before?

……

If you answer Yes to any of the following questions, please explain as clearly as possible including medication:

Do you have any serious or chronic illnesses? ___Yes ___No

……

Are you taking any prescribed medication? ___Yes ___No

……..

Do you have any skin conditions? ___ Yes ___No

Do you have any allergies or sensitivities? ___Yes ___ No

……..

Do you have high blood pressure? ___Yes ___No

Do you have varicose veins or distended capillaries? ___Yes ___No

Do you have heart disease? ___Yes ___No

Do you have pacemaker? ___Yes ___No

Have you ever had a cardio-vascular surgery? ___Yes ___No

……..

……

Do you have migraines? ___Yes ___No

Do you often have headaches? ___Yes ___No

Do you suffer from Anxiety or Depression? ___Yes ___No

……..

……

Do you have any pain in your joints? ___ Yes ___No

Do you have arthritis? ___Yes ___No

Do you have any muscular pains and aches? ___Yes ___No

……

Do you suffer from epilepsy? ___Yes ___No

Do you have diabetes? ___Yes ___No

Do you have asthma? ___Yes ___No

Do you have any contagious diseases? ___Yes ___No

Do you suffer from claustrophobia? ___Yes ___No

……

Have you ever or are you being treated for cancer? ___Yes ___No

……

Have you ever had any surgery (if yes please give year)? __Yes ___No

……..

Have you had any injures within last two years? ___Yes ___No

……

Are you pregnant or nursing? ___Yes ___No

Do you wear contacts? ___Yes ___No

Do you wear dentures? ___Yes ___No

……..

Are you currently being treated by physician for any reason? __Yes __No

…….

Do you have any other medical problem I should know about? __Yes __No

……

Are you taking any other than prescribed medication like vitamins, herbs or any other over the counter supplements? ___Yes ___No

How much water do you drink a day? ___glasses

Do you exercise regularly? ___Yes ___No

Please describe your level of stress (0-10) _____

Is your diet well-balanced? ___Yes ___No

Comments ……

……

The information I have given is true to the best of my knowledge, and I have not withheld any information concerning my health. If I continue therapy I agree to update my massage therapist as to any changes in my medical profile if they occur and understand that there shall be no liability on the massage therapist part if I fail to do it so.

Client signature……..date……

Massage therapist signature…….date ……..

Therapeutic Touch

www.therapeutictouchbodyworks.com