Massage Intake and Waiver/Release Form

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ phone: _____

Physician/Healthcare Provider name: _____ phone: _____

Referred by: _____

Massage Experience:

Have you ever received professional massage/bodywork before ☐ Yes ☐ No

If Yes, how recently:

	1 week ago		1-3 months ago
	2 weeks ago		Longer than 3 months ago

Are you currently pregnant? ☐ Yes ☐ No

What types of massage/bodywork do you prefer? (circle all that apply)

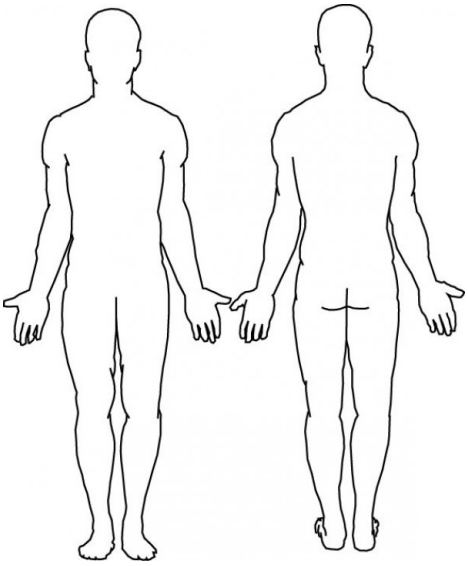
Swedish/relaxation	Therapeutic	Passive stretching	Hot stone
Deep tissue	Lymphatic	Cupping therapy	Other (specify)

What kind of pressure do you prefer? (circle) Light Medium Firm

Health History:

Please answer honestly. Massage may not be indicated for certain conditions. Please mark conditions that you have had or are currently under treatment for:

	Recent injury	(if yes, describe)	
	Allergies	(if yes, describe)	
	Hardware, screws or pins		Recent surgery
	Pacemaker		phlebitis
	Vertigo		deep vein thrombosis/ blood clots
	Contagious skin condition		joint disorder/rheumatoid arthritis/osteoarthritis
	Open sores or wounds		osteoporosis
	tendonitis		headaches/migraines
	Artificial joint		Current fever
	Easy bruising		Swollen glands
	Bleeding disorder		Taking blood thinners
	Heart condition		diabetes
	High or low blood pressure		cancer
	circulatory disorder		fibromyalgia
	Varicose veins		pitted edema



Please circle the areas of the body that cause you discomfort.

Please list any other conditions or concerns:

_____

_____

_____

_____

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.
- ***For Cupping Therapy***, I understand that this service is not recommended for persons who are currently taking blood thinners or have a bleeding disorder or history of blood clots. I understand that there is the possibility of discolorations or bruise-like markings or soreness that can occur from breaking up myofascial congestion or stagnation in my body. I further understand that the discolorations or bruise-like markings are contusions (bruises) and will dissipate from a few hours to as long as 2 weeks, in some cases, in relation to my after-care activities.
- ***Muscle Recovery & Mobility*****,** I understand that this service is not recommended for persons who are currently taking blood thinners, have artificial joints, have a pacemaker, have osteoporosis or are pregnant**.**
- I further understand that massage/bodywork should not be construe as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental of physical ailment of which I am aware.
- I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments., diagnosis, prescribe, or treat any physical or mental illness, and that nothing said I the course of the session given should be construed as such.
- Massage/bodywork 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.
- I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination for the session, and I will be liable for payment of the scheduled appointment.
- **I understand that I must give at least 24-hour notice for cancellation or rescheduling an appointment. If cancelling/rescheduling with less than 24-hour notice, the practitioner reserves the right to charge the full amount for the scheduled appointment.**
- Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Legal Guardian (in case of a minor): _____ Date: _____