Massage Therapy

CLIENT CONSULTATION & CONSENT FORM

Appointment Day & Time:

DD MM YY HH:MM

Please fill out this form on your first appointment.
The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Full Name

Address

Zip / Postal Code

City / Town

Phone

Emergency Contact Phone

Male Female

Age

Under 16 16-30 30-50 50+

Email

Yes No

(Your email address will be used for appointment confirmations, and quarterly newsletters)
If you would like to subscribe to our newsletter and promotions please tick YES or tick NO

Have you had a professional massage before? Yes No

If yes, when was that and how often do you receive massage therapy?

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain

Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe

What type of massage are you seeking?

Relaxation Therapeutic/Deep Tissue Aid in Recovery from an Injury

Please tick if any of the following apply to you.

- Arthritis
- Asthma
- Cancer/Tumors
- Diabetes
- Osteoporosis
- Nervous/psychotic conditions
- Fibromyalgia
- Epilepsy
- Haemophilia
- Rashes
- Deep vein thrombosis/ Blood clots
- Slipped disc or cervical spondylitis
- Joint Replacement(s)
- Athletes Foot
- Sensitive skin
- Easy bruising
- Kidney infections
- Hormonal implants
- Heart Conditions/Disease
- Medical oedema (swelling)
- Inflamed nerve

Female clients only

Are you currently pregnant?

If yes, how far along and any risk factors?

Are you wearing?

- [ ] A Hearing Aid
- [ ] Contacts
- [ ] Dentures
- [ ] Pacemaker

What kind of pressure do you prefer?

- [ ] Light
- [ ] Medium
- [ ] Firm
- [ ] Very Firm

Do you suffer from chronic pain? If yes, please explain what makes it better and what makes it worse? ◯ Yes ◯ No

Do you sit for long hours at a workstation, computer, or driving? If yes, please describe ◯ Yes ◯ No

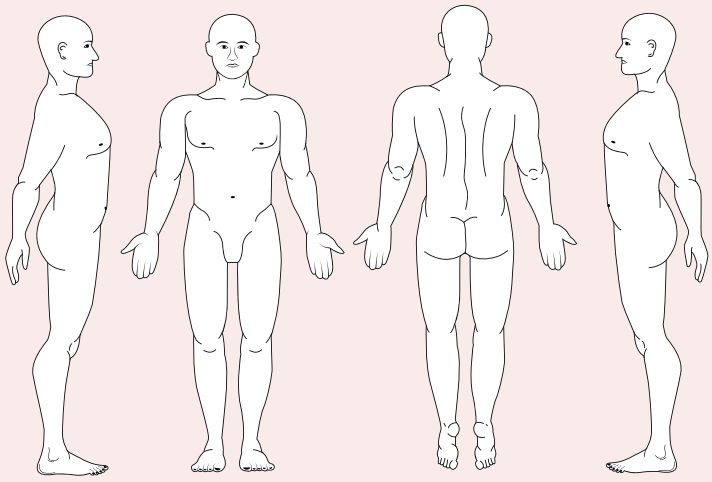
Do you have any recent injuries? If yes, please describe ◯ Yes ◯ No

Are you sensitive to touch/pressure in areas? If yes, please describe ◯ Yes ◯ No

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? If yes, please describe ◯ Yes ◯ No

How would you describe your stress levels from 1- 10 (1=low, 10=high):

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
If yes, please **Circle** any specific areas you would like the massage therapist to concentrate on during the session:



Please tick if any of the following apply to you today

- [ ] Suffering from fever or contagious or infectious diseases
- [ ] Diarrhoea and vomiting
- [ ] Skin diseases
- [ ] Varicose veins
- [ ] Consumed alcohol, recreational drugs or a heavy meal
- [ ] Undiagnosed lumps, bumps or pain
- [ ] Cuts, bruises, abrasions or sunburn
- [ ] Broken bone in the last 3 months

* If you have ticked yes, your treatment today may have to be modified to avoid certain areas of your body.

Do you have any particular goals in mind for this massage session? If yes, please explain ◯ Yes ◯ No

Are you currently under medical supervision or recently visited - doctor/consultant/physiotherapist/osteopath/ chiropractor/other? If yes, please describe

◯ Yes ◯ No

Are you currently taking any prescribed medication? If yes, please give details

◯ Yes ◯ No

Do you have any hypersensitive skin or allergies or sensitivities? If yes, please give details

◯ Yes ◯ No

Any Cardiovascular conditions?
(e.g. thrombosis, phlebitis (vein inflammation), high or low blood pressure, heart conditions)

◯ Yes ◯ No

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

Informed Consent, Waiver and Release

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions truthfully, and shared any knowledge of your medical conditions.

I waive and release massage therapist and staff who are operating this massage therapy from all claims, suits, losses and related cause of actions for damages that may arise in any way, direct or indirect, from this massage therapy.

I agree to keep the massage therapist updated as to any changes in my medical profile during today's and all future sessions, and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

Client (Printed Name)

Parent or guardian (if under 18 years of age)
Name & Signature

Client Signature

Date

Massage Therapist Name

Massage Therapist Signature

Date

Massage Therapist notes

Coronavirus
Liability Release Form

Due to the 2019-2020 outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- Dry cough
- Difficulty breathing
- Chills
- Nausea or vomiting
- Diarrhea
- Confusion
- New widespread muscle pain
- Headaches
- Fatigue
- Loss of taste & smell
- Bruising, redness, swelling, or cramping in lower legs and feet
- Red or purple toes

- [ ] I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- [ ] I affirm that I, as well as all household members, have not been diagnosed with COVID- 19 within the last 30 days.
- [ ] I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- [ ] I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.
- [ ] I understand that this business and my massage therapist cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each above statement and release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19. Your massage therapist and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

Client (Printed Name)

Client Signature

Date