Christinia's Therapeutic Massage

Massage Therapy Client Information & Waiver/Release Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Phone _____ Email _____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain: _____

_____

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

Please Explain: _____

_____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

____ Yes ____No

Please Explain: _____

_____

Please circle your stress level:

Low 1 2 3 4 5 High

Are you allergic to any Lotions or Oils? ____ Yes ____ No

Please Explain:_____

Client Intake Form

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

__ Headaches
__ Joint stiffness/swelling
__ Spasms/cramps
__ Broken/Fractured bones
__ Strains/Sprains
__ Back, hip pain
__ Shoulder, neck, arm, hand pain
__ Leg, foot pain
__ Chest, ribs, abdominal pain
__ Problems walking
__ Jaw pain/TMJ
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Other:_____

Circulator/Respiratory

__ Dizziness
__ Shortness of breath
__ Fainting
__ Cold feet or hands
__ Cold sweats
__ Stroke
__ Heart condition
__ Allergies
__ Asthma
__ High blood pressure
__ Low blood pressure
__ Other:_____

Digestive

__ Indigestion
__ Constipation
__ Intestinal gas/bloating
__ Diarrhea
__ Irritable bowel syndrome
__ Crohn's Disease
__ Colitis
__ Other:_____

Nervous System

__ Numbness/tingling
__ Fatigue
__ Sleep disorders
__ Ulcers
__ Paralysis
__ Herpes/shingles
__ Cerebral Palsy
__ Epilepsy
__ Chronic Fatigue Syndrome
__ Multiple Sclerosis
__ Muscular Dystrophy
__ Parkinson's Disease
__ Other:_____

Reproductive System

__ Pregnancy

Skin

__ Rashes
__ Allergies
__ Athlete's foot
__ Acne
__ Impetigo
__ Hemophelia

Other

__ Loss of Appetite
__ Depression
__ Difficulty concentrating
__ Hearing Impaired
__ Visually Impaired
__ Diabetes
__ Fibromyalgia
__ Post/Polio Syndrome
__ Cancer
__ Tuberculosis
__ Other:_____

I understand that a Massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the Massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the Massage Therapist of any changes in my status.

Client's signature_____ Date_____

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receipt of massage services from:

_____

Licensed Massage Therapist's Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.

2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.

3. Client hereby assumes full responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist.

_____ _____

Client Signature Client Printed Name

_____

Date

_____ _____

Massage Therapist Signature Massage Therapist Printed Name

_____

Date