

Massage Therapy Informed Consent

I, _____, understand that massage therapy provided by my therapist is intended to enhance relaxation, reduce tension induced pain, increase range of motion, and improve circulatory and lymphatic flow. Any other intended purpose will be discussed specifically by the therapist and written in comments below.

If I have any questions about the general benefits of massage, possible massage contraindications or treatments procedures, I will ask my therapist.

I am aware that the massage therapist does not diagnose any illness or disease, does not prescribe medications, and does not perform spinal manipulations.

I have informed the massage therapist of medications I take and all known physical and medical conditions I currently have. I will keep the therapist updated with any changes to my health and/or medications.

I understand I can leave any article of clothing on I wish. Draping will be used at all times and my modesty will be maintained throughout the massage. Draping and other procedures will be explained by the therapist.

A full body massage includes the chest (upper chest only for females- above the breast), abdomen, and hips. If I do not want any of these areas massaged, I will inform my therapist.

I understand all my medical information will be kept confidential at all times unless under life-or-death emergency and/or where law demands.

Comments:

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Client Health History

The thoroughness of your answers will help us provide better service and care for you. All information is kept completely confidential. Please print clearly.

Name: _____ Tel: (W) _____ (H) _____

Address: _____
(Street)

_____ (City) (State) (Zip)

EMERGENCY CONTACT: _____ **TEL:** _____

Birth Date: _____ Who referred you to us? _____

Occupation: _____ How long? _____

Number of children: _____ Ages: _____

Are you pregnant or trying to become pregnant? Y/N
If so, what trimester? _____ Complications? _____

Do you wear contacts? Y/N If so, Hard / Soft

Have you ever had a professional massage? Y/N If so, how many? _____

Are you allergic to any lotions, creams, oils, or aromas? Y/N
If so, list: _____

List and date any surgeries within the past year:

List and date any accidents/injuries within the past year:

List any medications and/or supplements, along with the dose, you currently take:

Please circle all conditions you **currently** experience:

Cancer	Skin disorder	Osteoporosis	Arthritis
Diabetes	Inflammation	High Blood Pressure	Depression/Anxiety
Fatigue	Pain	Low Blood Pressure	Heart Disease/problems
Edema	Digestive problems	Muscle spasms	Blood clots/phlebitis
Anemia	Breathing problems	Pain/swollen joints	Herniated disk
Headaches	Bulging disk	Seizure disorder	Contagious disease
Infection			
OTHER:			

Are you presently under a doctor's care? Y/N

If so, for what conditions? _____

List any areas of pain or concern: _____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____

Is the condition getting WORSE BETTER ABOUT THE SAME

What have you done to get relief? _____

Has there been a medical diagnosis? _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE THERAPIST OF ANY CHANGES TO MY HEALTH AND/OR MEDICATIONS.

SIGNED: _____ DATE: _____
(Client)

SIGNED: _____ DATE: _____
(Therapist)

Medical History Update Form

By signing this agreement, you are confirming that you have not had any updates to your massage therapy medical file since your last visit on _____.

This includes being or trying to become pregnant (if female), any recent accidents, injuries, or surgeries that would cause a contraindication, taking any new medications or supplements, and/or seeing a doctor for a new medical condition. It is your responsibility to inform your massage therapist of any updates to your medical history. Thank you for your understanding.

Client Signature

Date

Therapist Signature

Date