

Therapeutic Massage Medical History Form

Name: _____ Phone: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact / Relationship: _____ Phone: _____

E-mail: _____ Physician name and phone: _____

Surgical History: _____

Medications: _____

Last time you had a massage? _____

Do you have any tension or soreness in a specific area? Please specify: _____

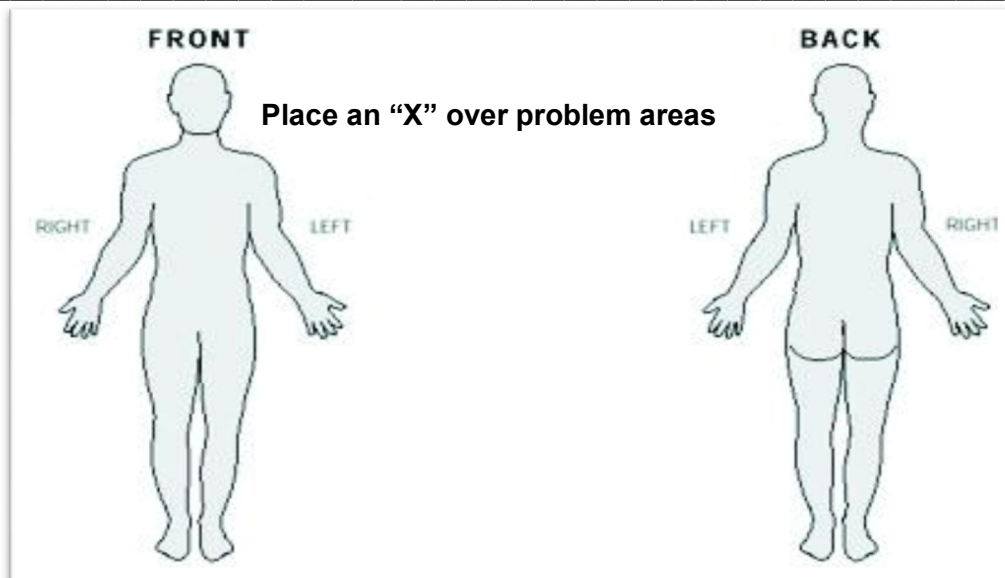
Referred by (so we know who to thank): _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage / bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please check appropriate boxes and explain as clearly as possible.

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Frequently suffer from stress <input type="checkbox"/> Joint or muscle pain <input type="checkbox"/> Diabetes <input type="checkbox"/> Frequent headaches or migraines <input type="checkbox"/> Pregnant <input type="checkbox"/> Suffer from arthritis <input type="checkbox"/> Wear contact lenses or dentures <input type="checkbox"/> High blood pressure <input type="checkbox"/> Take medication for blood pressure <input type="checkbox"/> Suffer from epilepsy or seizures | <ul style="list-style-type: none"> <input type="checkbox"/> Skin ailments or allergies <input type="checkbox"/> Varicose veins <input type="checkbox"/> Current infectious / contagious disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Bruise easily or bleeding disorders <input type="checkbox"/> Injuries or broken bones in the past two years <input type="checkbox"/> Cardiac or circulatory problems <input type="checkbox"/> Current or history of cancer <input type="checkbox"/> Current or history of blood clots <input type="checkbox"/> Current or history of kidney problems |
|---|---|

Comments: _____



Informed Consent and Massage Policies

- I understand that the massage I will be receiving here is for the purpose of stress reduction, relief from muscular tension or spasm and are non-sexual. I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.
- I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information and agree that there shall be no liability on the practitioners part should I fail to do so. I understand that if I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.
- All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons, or court order.
- If I cancel or miss a scheduled appointment without 24-hours notice, a full visit fee for that appointment will be charged. Your appointment day/time is your responsibility as we do not do appointment reminder calls.**
- By signing this release I hereby waive Julie Barton of Optimum Wellness from all liability past, present, and future relating to massage and bodywork.

Signature: _____ Date: _____

Consent to Treatment of a Minor: By my signature below, I hereby authorize _____ to administer massage and / or bodywork techniques to my child or dependent, as they deem necessary.

Parent Signature: _____ Date: _____