Massage Therapy Consultation Form

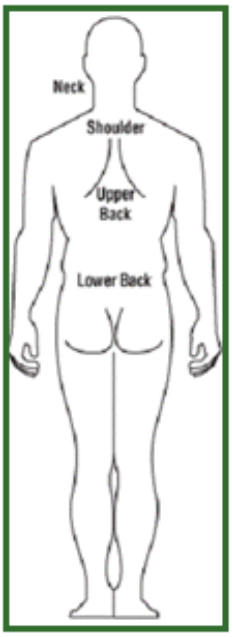
□ Name _____

Address _____ City _____ State ____ Zip_____

Phone # _____ Email Address_____

Birthday _____ How did you hear about us? Friend Google Facebook SpaFinder Other_____

Do you ever experience - **Headaches Migraines Vertigo TMJ Sciatic Pain Joint Pain Numbness Tingling**
No □ Other, please explain _____



Are there any particular areas of the body you would like your Massage Therapist to focus on?
Please explain or mark areas of concern _____

What kind of pressure do you like? **Light □ Medium □ Firm □ Deep □**
Please explain _____

Are there any particular areas of the body your Massage Therapist should avoid?
Scalp □ Face □ Neck □ Feet □ Glutes □ Other, please explain _____

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

Do you have any recent sunburn, bruises, cuts or scrapes? **No □ Yes □**
If yes, please explain _____

Are you currently taking any medications? **No □ Yes □**
If yes, please explain _____

Do you have any medical conditions that need to be brought to your Massage Therapist's attention?
No □ Yes □ If yes, please explain _____

I understand that the service 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 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. I affirm that I gave stated all of my known medical conditions and have answered all questions honestly. I agree to keep the Massage Therapist updated as to any changes in my medical profile and understand that there shall be no liability on the Massage Therapists part should I fail to do so. I understand that the Massage Therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is a contraindicated.

Client Signature _____ Date _____