Massage Consent

Consent for Massage Therapy

__ I confirm I am at least 18 years of age.

__ I understand massage therapy is provide for stress reduction, relaxation, relief from muscle tension, and improvement of circulation.

__ The therapy, including the process and objective, has been explained to me before undergoing massage therapy.

__ I have been given the opportunity to ask questions regarding any benefits, risks, or possible complications of the therapy.

__ I understand there is no implied or stated guarantee of this therapy's success.

__ If I experience any pain or discomfort during the session, I will inform my therapist immediately so they may adjust their pressure and methods to my level of comfort. I will not hold my therapist responsible for painI experience during or after the session.

__ I understand massage therapy is not a substitute for medical care. I understand my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

__ I confirm that I have given an accurate account of my medical history, including any allergies or medications that I am currently taking or intend to take.

__ I understand this an elective therapy and is not medically necessary.

__ I understand massage is entirely therapeutic and non-sexual in nature.

__ I understand draping clothes will be used for my privacy. At no point will genitalia or women's breasts be exposed or touched.

__ I understand any sexually suggestive, illicit, or other remarks that make the therapist uncomfortable will result in the immediate termination of the session and I will be responsible for the full session payment.

With my signature below, I confirm that I have read fully and understand the information in this consent form and all details included. I have provided an accurate account of my medical history including any medications I take or intend to take, and any medical procedures I intend to undergo. By signing below, I agree to accept all and full responsibility for any risks, injuries, damages, or side effects that may occur as part of the massage. I will not hold my therapist (name recorded below) responsible for any conditions present, but not disclosed at the time of therapy, that may affect the treatment.

Printed Client's Name	Signature	Date
_____	_____	_____
Printed Therapist's Name	Signature	Date
_____	_____	_____

Massage Therapy

Intake for Massage Therapy

Name _____ Birthday _____

Address _____

City _____ State/Province _____ Zip/Postal Code _____

Phone # _____ Email _____

Emergency Contact Name & Number _____

Would you like to be added to our email list for information and discounts? ☐ Yes ☐ No

How did you hear about us? _____

Medical History

Are you currently taking any medications or vitamins? ☐ Yes ☐ No

If yes, please list: _____

Do you have any allergies? ☐ Yes ☐ No

If yes, explain: _____

Have you had any facial or dermatology services in the past 30 days? ☐ Yes ☐ No

If yes, please explain: _____

Check All that Apply

Acne	Lupus	Eczema	Psoriasis
Diabetes	Pregnant	Heart Condition	Shingles
Fever Blisters	Seborrhea	HIV	Warts
High Blood Pressure	Hyper/Hypo Thyroid	Insomnia	Depression
Hypo Pigmentation	Arthritis	Sinus Infection	Hepatitis
Hyper Pigmentation	Low Blood Pressure	Rashes	Other

Please explain anything else in your medical history we should know about, including any cancer diagnoses, current or former treatments for cancer, or surgeries. _____

_____

Select the products you currently use

Body Lotion	Day Cream	Toner	Facial Scrub
Cleansing Cream	Exfoliants	Body Scrub	Neck Cream
Eye Cream	Hand Cream	Eye Makeup Remover	Other