Client History Form

Name _____ Date of Birth _____

What is your occupation? _____

What is your reason for having massage therapy treatments? _____

Please list all allergies (e.g. pet dander, smoke, strong scents). _____

Please list all prescription and non-prescription medications as well as herbal and vitamin supplements.
_____
_____
_____

Please list any injuries and the treatments you're receiving.
_____
_____
_____

Please list any surgeries.
_____
_____

Please list any current conditions/illnesses diagnosed by your physician and the treatments you're receiving.
_____
_____
_____

Consent for Therapy and Waiver of Liability

I understand that massage therapy is not a substitute for medical treatment and that it is recommended that I see my physician for any conditions that I may have.

I understand that I must inform my massage therapist as to any changes in my health status prior to and during my treatment.

I understand that any inappropriate behaviour or remarks made by me will not be tolerated.

I understand that my massage therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is contraindicated.

If I choose to provide my email address, I authorize my massage therapist to communicate with me via email. My email address will only be used for information pertaining to my treatment.

In signing this Consent for Therapy and Waiver of Liability, I understand and agree that this consent will apply to all massage therapy treatments performed by my massage therapist.

Signature _____ Date _____