A picture containing text

Description automatically generated

**Personal Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Province/Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge.**

1. Do you have any difficulty lying on your front, back or side? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any allergies to oils, lotions or ointments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you experience stress in your work, family or another aspect of your life? \_\_\_\_\_\_\_\_\_\_\_\_If yes, how do you think it has affected your life? Muscle tension \_\_\_Anxiety \_\_\_Irritability \_\_\_Sleep \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? \_\_\_\_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you had any recent injuries? \_\_\_\_\_\_\_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you ever been in a car accident? \_\_\_\_\_\_\_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are you currently under medical supervision? \_\_\_\_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you recently had surgery? \_\_\_\_\_\_\_ Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Are you currently taking any medications? (Please include any supplements, homeopathic and herbal remedies) \_\_\_\_\_\_\_\_ Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Please check any condition below that applies to you:

\_\_ contagious skin condition \_\_chronic pain conditions \_\_ open sores/bruising

\_\_ blood clots \_\_ easy bruising \_\_ arthritis \_\_ osteoporosis \_\_ recent fracture \_\_ epilepsy \_\_ recent surgery \_\_ headaches/migraines \_\_depression/anxiety

\_\_ sprains/strains \_\_ diabetes \_\_ current fever

\_\_ numbness/tingling \_\_ swollen glands \_\_ fibromyalgia

\_\_autoimmune disease \_\_allergies (explain) \_\_ allergies/sensitivities

\_\_ back/neck injury \_\_ heart condition \_\_varicose veins

\_\_ high or low blood pressure \_\_ carpal tunnel \_\_ circulatory disorder

PLEASE LIST ANY OTHER HEALTH PROBLEMS YOU MAY HAVE IN ORDER TO ENSURE A SAFE MASSAGE SESSION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant or breastfeeding? **Y N**

What pressure do you prefer? **Light Medium**

Any areas you don’t want massaged? (ie: feet,hands) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas you want focused on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your goals for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What level of conversation do you like during your massage? None \_\_\_\_I love to chat \_\_\_\_\_

**POLICY – PLEASE READ CAREFULLY**

* If cancellation is necessary, please give 24-hour notice.
* If you have a cold, flu, sore throat, stomach virus, poison ivy, skin rash, anything contagious please reschedule your appointment.
* Clients must provide a health history and update when necessary.
* Payment is expected at the time service is rendered.
* Sexual harassment is not tolerated.
* If the practitioner’s safety feels compromised, the session is stopped immediately.
* We will send you home if you are under the influence of alcohol or drugs.
* Please shower prior to your session.
* Do not eat a heavy meal less than two hours prior to the treatment.
* Wear loose or comfortable clothes
* Drink plenty of fluids after treatment, as your body will eliminate any toxins.
* If you experience a mild to moderate headache after treatment, this is normal in most individuals due to detoxification.

**Massage Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (client) understand that the Aromatherapy massage provided by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is intended to enhance relaxation, reduce muscle tension and offer comfort and a positive experience of touch.  The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me.

I understand that massage is not a substitute for medical treatment or medications, and that it is recommended that I work with my medical physician for any conditions I may have. I am aware that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of the massage treatment. I accept responsibility for any contradictions or complication that may result.

I have informed the practitioner of all my known physical conditions, medical conditions and medications, and I will keep them updated on any changes. I understand that there shall be no liability on the practitioner’s part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I must immediately communicate that to the therapist so the treatment can be adjusted. I have reviewed the policies, and I understand them and agree to abide by them.  I acknowledge that with any treatment there can be risks and I assume those risks.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_