CLIENT CONSULTATION FORM

Name _____ Date_____
First Middle Initial Last

Address_____

City/State/Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Email_____

Emergency Contact _____Phone (_____)_____

Referred by _____Reason for appointment_____

General & Medical Information

Occupation _____ DOB _____ Male Female

Physician _____ Phone (_____)_____

Have you ever received a massage/facial/waxing? Yes If yes, how recently?_____ No

What type of pressure do you prefer? Light Medium Firm Deep Tissue

Please take a moment to carefully read the following information and check mark as indicated. If you have a specific medical condition or specific symptoms, a service may be contraindicated and not advised. If you check mark any of the conditions, please explain as clearly as possible below.

___ Allergies
___ Aneurysm
___ Arthritis: Osteo, RA, AS, etc.
___ Athlete's foot
___ Back/neck pain
___ Blood pressure = high or low
___ Bruises/burns
___ Cancer Where:_____
___ Cardiac/Heart condition
___ Circulatory issues
___ Contact lenses
___ Contagious diseases
___ C.O.P.D.
___ Dentures
___ Diabetes
___ Epilepsy or seizures
___ Fibromyalgia
___ Headaches/Migraines
___ Hemophilia
___ Injuries/Broken bones
___ Joint swelling/dysfunction
___ Kidney stones
___ Leukemia
___ Numbness/tingling
___ Osteoporosis
___ Pregnant/Lactating
___ Stress/anxiety
___TMJ syndrome
___Varicose veins
Accidents or injuries in past year?_____
_____
_____

Explanation of any check marks above:_____

_____

_____

_____

Do you have any other conditions not listed above?_____

_____

_____

_____

Are you taking any medications I should know about and have you taken them today? Please explain.

_____

_____

_____

_____

_____

Consent for Therapy

I understand and agree that:

- The relationship between the client and the therapist is strictly confidential and all information provided to the therapist will be kept confidential.
- My body will be properly draped at all times for modesty, comfort, security and warmth.
- The session given here is for the sole purposes of stress reduction, relaxation, relief from muscle tension or spasm, and/or to increase circulation, energy flow, cleansing or hair removal purposes.
- The session is solely for therapeutic purposes and the therapist has the right to be free from any harmful, offensive, suggestive, and/or physical contact or behavior. If these guidelines are violated, the therapist will terminate the session immediately. No refund will be provided.
- I have the right to request and require that any procedure or technique be modified, changed, stopped, or simply not performed.
- I will inform the therapist of any massage discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- The health information given is accurate and I agree to update the therapist with any changes at future appointments as appropriate before each session.
- It may be necessary to obtain permission from my healthcare provider to receive or continue therapy.
- The therapist does not diagnose or prescribe for medical illnesses, disease, or any other physical or mental disorders.
- The therapist does not do spinal manipulations. These sessions are not a substitute for primary medical treatment, medical examinations or diagnosis and it is recommended that a physician be seen for any ailment that you may have.
- Any session performed on a minor will be with the written consent of the minor's guardian. The guardian must remain present. This can be arranged while assuring the minor's privacy and modesty.
- Should I have to cancel an appointment for any reason, I agree to give the therapist a 24-hour notice. If I fail to provide adequate notice, I will be responsible for a cancellation fee equal to 100% of the scheduled service price.
- Your therapist is an independent professional and is solely responsible for your sessions.
- By signing this form, I also give my consent for any future sessions scheduled.

I have read and understand this form in its entirety and hereby freely give my permission to be serviced. I have stated all conditions that I am aware of in the health history portion and this information is true and accurate to the best of my knowledge. I agree to inform my therapist of any changes in my health status before each session.

Client's Signature_____ Date_____

Client's Printed Name_____

_____

(Print Name—Parent/Guardian) (Parent/Guardian's Signature)

Guardian must sign this consent form for any person under the age of 18 years old receiving services.