Massage
Client Information and Consent Form

Name: ______________________________ Date of Birth: __________________

Address: ____

City: _________________________ State: __________ Zip: _______________

Home Phone: ____________ Cell Phone: ____________ Work Phone: _____________

Occupation: ____________________ Hobbies, Activities, Sports: __________________

Emergency Contact: __________________________ Phone: __________________

Physician: _____________________________ Phone: ____________________

Have you received a massage before? Yes or No By Who? _____________________

I was referred by: ____

Medical History:

Do you have any of the following?	YES	NO
Circulatory/Heart Problems		
Varicose Veins		
Arthritis		
Gout		
Epilepsy		
Tuberculosis		
Frequent Headaches		
Cancer		
High Blood Pressure		
Are you wearing		

contacts?		
Do you have any other medical condition I should be aware of?		

Please Explain: ____

If you answer YES to any of the questions in this section, please explain briefly:
(Circle One)

Have you had surgery in the past three (3) years?
Yes or No

Explanation: ____

Have you had any broken bones in the past two (2) years?
Yes or No

Explanation: ____

Are you allergic to any oils or lotions?
Yes or No

Explanation: ____

Do you lack normal sensation to any areas of your body? (Any painful areas, etc?)
Yes or No

Explanation: ____

Are you sensitive to touch/pressure in any areas?
Yes or No

Explanation: ____

Do you have any communicable diseases?
Yes or No

Explanation: ____

Body Scrub Only
Have you shaved in the last 24 hours?
Yes or No

Do you have sensitive skin?
Yes or No

Please take a moment and carefully read the following information. Sign and date where indicated.

Waiver of Liability

I understand that the massage/body work I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage/body work should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment.

I understand that the massage therapist/ body workers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, an that nothing said in the course of the session(s) given should be construed as such.

Because massage/body work should not be administered under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's or Serenity Day Spa's part.

It is also understood that any confusing or sexually suggestive remarks or touch from me will result in immediate termination of the session, and I will be liable for payment for the entire scheduled appointment.

I understand that session fees are to be paid in full at the time of service. And I agree if possible to give a 24-hour notice if I need to cancel an appointment.

Client's Signature: ______________________________ Date: ______________

Therapist's Signature: ______________________________ Date: ______________

By Initialing below, I agree that I have read my previously listed information and medical history report and that no changes need to

be made. If changes have occurred, I have listed them below in the space provided.

Client's Initials:												
Date:												
Therapist's Initials:												
Date:												

Changes to Information/Medical History:

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