Massage therapy clinic

Phone: (508) 384 ~ 3436
Email: MyMassageTherapyClinic@yahoo.com
Website: www.MyMassageTherapyClinic.com

Name:_____

Mailing Address: _____

_____

Email Address: _____
Cell Phone: _____
Day Time Phone: _____
Evening Phone_____

Birthday: Month_____ Day_____ Year_____

Occupation: _____

Emergency Contact: Name_____ Number_____

May we contact you by: Phone? Y or N Email? Y or N Text? Y or N Mail? Y or N

Referred by: Word of Mouth ____ Internet _____ Newspaper ____ Other_____

Any special considerations you need during your Massage?_____
_____
(i.e.: **Allergies to nuts**, sensitive skin to oils, no lotion on face, no foot massage, sensitive areas due to injury)

Please list all medications you are currently taking:_____
_____

Have you ever had a massage before? Y or N..... If Yes what kind _____
Exercise Habits?: _____

OVER →

Please Circle any of the following that pertain to you:

Cardiac Problems	High BP	Low BP	Blood Thinners	Diabetes
Varicose Veins	Arthritis	Allergies	Joint Swelling	Headaches
Bruise Easily	Contact Lenses	Back Pain	Skin Disorders	Stress
Epilepsy	Numbness/Pain	Surgeries	Spinal Problems	Cancer
Sore Muscles	Low Blood Sugar	Clotting Disorder	Fibromyalgia	Sciatica

Comments:_____

_____

_____

_____

Please take a moment to carefully read the following information and initial on each line provided.

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

I further understand that massage **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 that I am aware of._____

I understand that massage practitioners **are not qualified** to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such._____

Because massage **should not be performed under certain medical conditions**, I agree that I have stated all my known medical conditions, and answered all questions **honestly**. I agree to keep the practitioner updated as to any changed in my medical history and understand that there shall be no liability on the practitioners' part should I forget to do so._____

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in **immediate termination** of the session, and I will be liable for payment of the scheduled appointment._____

Cancellation, No Show & Late Arrival Policy:
Cancellations with less than 12 hour notice will result in 50% charge of service cost.
Not Showing for scheduled appointment will result in a 100% charge of service cost.
Late Arrival will only receive the remaining time allotted for their scheduled appointment but will be responsible for full payment of service cost.
Signing below acknowledges reading and understanding the above terms:

Client Signature: _____ Date: _____