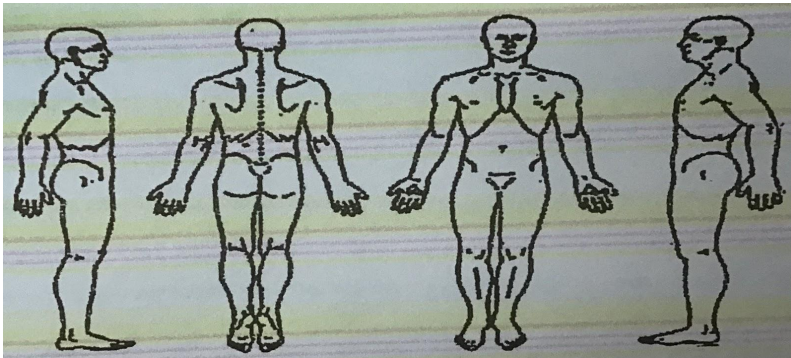


MESSAGE INFORMED CONSENT FORM

FIRST: _____ MIDDLE: _____ LAST: _____
BIRTHDATE: ____/____/____ FEMALE _____ MALE _____ PHONE: _____
PHONE: _____
STREET: _____ CITY: _____ STATE: _____ ZIP: _____
EMAIL: _____
EMERGENCY CONTACT: _____ PHONE: _____
HOW DID YOU HEAR ABOUT US? _____
REFERRED BY? _____
OCCUPATION: _____ HOBBIES: _____
HOW WOULD YOU RATE YOUR OVERALL HEALTH? _____ EXCELLENT _____ VERY GOOD _____ GOOD _____ FAIR _____ POOR
HAVE YOU HAD PREVIOUS MASSAGE? _____ NO _____ YES: RESULTS: _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR
WHAT IS YOUR GOAL/CONCERN FOR TODAY'S SESSION? _____
HERE IS A LIST OF THINGS MASSAGE CAN HELP WITH. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:
REDUCE STRESS AND ANXIETY REDUCE MUSCLE SORENESS AND TENSION IMPROVE CIRCULATION
IMPROVE IMMUNE FUNCTION IMPROVE MOOD REDUCE PAIN SLEEP BETTER INCREASE RELAXATION
IMPROVE FLEXIBILITY AND RANGE OF MOTION LOWER HEART RATE AND BLOOD PRESSURE
WHAT KIND OF PRESSURE DO YOU PREFER? _____ LIGHT _____ MEDIUM _____ FIRM
ARE YOU SENSITIVE TO TOUCH OR PRESSURE IN ANY AREA? _____ NO _____ YES: _____
DO YOU EXPERIENCE ANY DIFFICULTY LYING EITHER ON YOUR FRONT OR YOUR BACK? _____ YES FRONT _____ YES BACK
ARE THERE CERTAIN STANDING OR SITTING POSITIONS YOU NEED TO AVOID OR THAT ARE PAINFUL OR
UNCOMFORTABLE? _____ NO _____ YES: _____
HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN? _____ NO _____ YES: _____
IS THERE ANY AREA WHERE YOU SEEM TO HOLD A LOT OF TENSION? _____
HAVE YOU EVER BEEN HOSPITALIZED? _____ NO _____ YES: _____
HAVE YOU HAD SIGNIFICANT FRACTURES, FALLS, AUTO ACCIDENTS, ETC.? _____ NO _____ YES: _____
ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITIONS? _____ NO _____ YES: _____
LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION: _____

INDICATE ON THE DRAWINGS BELOW WHERE YOU HAVE PAIN/SYMPTOMS.



USING A SCALE FROM 1-10 (10 BEING THE WORST), HOW WOULD YOU RATE YOUR PROBLEM?

0 1 2 3 4 5 6 7 8 9 10

IF YOU HAVE PAIN(S), HOW OFTEN DO YOU EXPERIENCE YOUR PAIN SYMPTOMS?

_____ CONSTANTLY (76-100% OF THE TIME) _____ FREQUENTLY (51-75% OF THE TIME)

_____ OCCASIONALLY (26-50% OF THE TIME) _____ INTERMITTENTLY (1-25% OF THE TIME)

HOW WOULD YOU DESCRIBE THE TYPE OF PAIN? _____

_____ SHOOTING _____ NUMB _____ DULL _____ TINGLY

_____ SHARP WITH MOTION _____ ACHY _____ STIFF _____ DIFFUSE _____ SHARP _____ BURNING

_____ STIFF _____ STABBING WITH MOTION _____ SHOOTING WITH MOTION _____ ELECTRIC LIKE WITH MOTION

HOW ARE YOUR SYMPTOMS? _____ GETTING WORSE _____ STAYING THE SAME _____ GETTING BETTER

DOES PAIN INTERFERE WORK? _____ NOT AT ALL _____ A LITTLE BIT _____ MODERATELY _____ QUITE A BIT _____ EXTREMELY

DOES PAIN INTERFERE WITH ACTIVITIES? _____ NO _____ LITTLE BIT _____ MODERATELY _____ QUITE _____ EXTREMELY

DO YOU CONSIDER THIS PROBLEM TO BE SEVERE? _____ YES _____ YES, AT TIMES _____ NO

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HOW DO YOU THINK YOUR PROBLEM BEGAN? _____

WHAT AGGRAVATES YOUR PROBLEM? _____

WHAT HELPS YOUR PROBLEM? _____

	YES PAST	NOW	NO		YES PAST	NOW	NO
Pregnancy	___	___	___	Anemia	___	___	___
Headaches	___	___	___	Raynaud's	___	___	___
Neck Pain	___	___	___	Easy Bruising	___	___	___
Whiplash	___	___	___	Angina	___	___	___
Upper Back Pain	___	___	___	Kidney Stones	___	___	___
Mid Back Pain	___	___	___	Kidney Disorders	___	___	___
Low Back Pain	___	___	___	Bladder Infection	___	___	___
Herniated Disc	___	___	___	Painful Urination	___	___	___
Shoulder Pain	___	___	___	Loss of Bladder	___	___	___
Elbow/Upper Arm Pain	___	___	___	Frequent Urination	___	___	___
Wrist Pain	___	___	___	Abdominal Pain	___	___	___
Hand Pain	___	___	___	Irritable Bowel Syndrome	___	___	___
Hip Pain	___	___	___	Abnormal Weight Gain	___	___	___
Upper Leg pain	___	___	___	Abnormal Weight Loss	___	___	___
Knee Pain	___	___	___	Loss of Appetite	___	___	___
Ankle/Foot Pain	___	___	___	Crohn's	___	___	___
Jaw Pain	___	___	___	Hernia	___	___	___
Whiplash	___	___	___	Ulcer	___	___	___
Joint Pain/Stiffness	___	___	___	Hepatitis	___	___	___
Arthritis	___	___	___	Liver/Gall Bladder Disorder	___	___	___
ALS	___	___	___	General Fatigue	___	___	___
Parkinson's	___	___	___	High Stress/Anxiety	___	___	___
Multiple Sclerosis	___	___	___	Panic Attacks	___	___	___
Neuritis/Neuralgia	___	___	___	Fibromyalgia	___	___	___
Fibrositis	___	___	___	Hypothyroidism	___	___	___
Rheumatoid Arthritis	___	___	___	Hyperthyroidism	___	___	___
Cancer	___	___	___	Endocrine Disorders	___	___	___
Autoimmune Disease	___	___	___	Muscular Incoordination	___	___	___
Osteoporosis	___	___	___	Visual Disturbances	___	___	___
Orthopedic Pins/Plates	___	___	___	Dizziness	___	___	___
Tumor, Cysts, Lipomas	___	___	___	Diabetes	___	___	___
Asthma/Breathing Problems	___	___	___	Excessive Thirst	___	___	___
Pneumonia	___	___	___	Poor Sleep / Insomnia	___	___	___
Chronic Sinusitis	___	___	___	Tinnitus, Ear Ringing	___	___	___
Heart Problems	___	___	___	Prostate Problems	___	___	___
High Blood Pressure	___	___	___	Smoking / Tobacco Use	___	___	___
Low Blood Pressure	___	___	___	Drug / Alcohol Dependence	___	___	___
Heart Attack	___	___	___	Allergies	___	___	___
Chest Pains	___	___	___	Depression	___	___	___
Stroke	___	___	___	Grieving	___	___	___
Peripheral Artery Disease	___	___	___	Systemic Lupus	___	___	___
Blood Clots, Phlebotitis	___	___	___	Epilepsy	___	___	___
Hemophilia	___	___	___	Dermatitis/Eczema/Rash	___	___	___
Varicose/Spider Veins	___	___	___	HIV/AIDS	___	___	___
Bad Circulation	___	___	___	Rash	___	___	___
Gout	___	___	___	Osteoarthritis	___	___	___
Pregnant	___	___	___	Other Conditions:	___	___	___

PLEASE READ AND INITIAL BEFORE EACH STATEMENT.

___ CANCELLATIONS/RESCHEDULES MUST BE MADE NO LESS THAN 24 HOURS OR WILL BE FULLY CHARGED.

___ IF LATE, THE SESSION WILL END AT THE APPOINTED TIME.

___ MASSAGE THERAPY IS FOR THE PURPOSE OF STRESS REDUCTION, RELIEF FROM MUSCLE TENSION OR SPASM, OR FOR INCREASING CIRCULATION AND ENERGY FLOW. I WILL INFORM MY MASSAGE THERAPIST IF I FEEL DISCOMFORT.

___ I UNDERSTAND THAT THE MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, DISEASE, OR ANY OTHER PHYSICAL OR MENTAL DISORDER. AS SUCH, THE MASSAGE THERAPIST DOES NOT PRESCRIBE MEDICAL TREATMENT OR PHARMACEUTICALS, NOR DO THEY PERFORM ANY SPINAL MANIPULATIONS. IT HAS BEEN MADE VERY CLEAR TO ME THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS AND/OR DIAGNOSIS AND THAT IT IS RECOMMENDED THAT I SEE A PHYSICIAN FOR ANY AILMENTS THAT I HAVE.

___ I HAVE STATED ALL KNOWN MEDICAL CONDITIONS AND WILL UPDATE THE THERAPIST ON MY PHYSICAL HEALTH.

___ I UNDERSTAND AND AGREE THAT I AM RECEIVING MASSAGE THERAPY ENTIRELY AT MY OWN RISK. IN THE EVENT THAT I BECOME INJURED EITHER DIRECTLY OR INDIRECTLY AS A RESULT, IN WHOLE OR IN PART, OF THE AFORESAID MASSAGE THERAPY, I HEREBY HOLD HARMLESS ALL CLAIMS AND LIABILITY WHATSOEVER.

___ MASSAGE GIVEN HERE IS THERAPEUTIC. ANY SEXUALIZATION ATTEMPT WILL NOT BE TOLERATED AND IS GROUNDS FOR TERMINATION OF THE MASSAGE AND I WILL BE LIABLE FOR PAYMENT OF THE SCHEDULED APPOINTMENT.

CLIENT SIGNATURE

DATE

CONSENT TO TREATMENT OF MINOR: I HEREBY AUTHORIZE MASSAGE AND BODYWORK TECHNIQUES FOR MY CHILD.

SIGNATURE OF PARENT OR GUARDIAN

DATE