Body Speak LLC

Therapeutic Massage

MT113388

CLIENT INFORMATION AND CONSULTATION FORM

NAME:			
ADDRESS:			
PHONE:	HOME:	WORK:	CELL:
EMAIL:			
EMERGENCY CONTACT:			
OCCUPATION:			
DATE OF BIRTH:			
Have you had professional therapeutic massage before?	YES if yes how long ago?	NO	

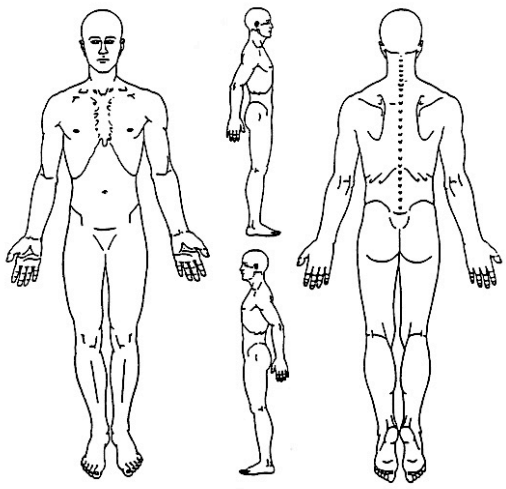
ANSWER THE FOLLOWING WITH YES OR NO & EXPLAIN IF NECESSARY

Allergies:	Diabetes:	
Arthritis:	High/Low Blood Pressure:	
Blood Clots:	Pregnant:	Due Date:
Cancer:	Seizures:	
Circulation Disorders:	Skin Problems:	
Contact Lenses:	Varicose Veins:	
Contagious Diseases:		
List all current medications:		
List any other medical conditions, major illness, broken bones, surgeries, or accidents that you have had within the last 3 years:		

ON THE DIAGRAM TO THE RIGHT

Circle the areas of the body that you feel need the most attention in the massage session:

Place an X over the areas that you wish to have avoided:



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PLEASE READ & INITIAL THE FOLLOWING STATEMENTS

1	I am aware that draping will be used during the massage session.	
2	Breast massage is not performed on female clients without written consent of the client prior to the massage session.	
3	The massage treatment is for the sole purpose of stress reduction, relief from muscle tension or spasm and to increase circulation and energy flow.	
4	I understand that the Massage Therapist does not diagnose, prescribe medical treatments or pharmaceuticals, and does not perform any spinal adjustments.	
5	Massage Therapy is not a substitute for medical examination or diagnosis. If I have any serious medical diagnosis I may be required to provide a physicians written consent prior to services.	
6	It is my (the Client), responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job.	
7	I understand that my (the Client), feedback is an essential element in my treatment, therefore if at any time I or the Massage Therapist should become uncomfortable during the massage, I or the Therapist may ask to end the massage session, and the session will end.	
8	I understand that If I choose to have Silicone Cupping as part of my massage session that discoloration/ broken capillaries, tenderness, redness and/or itching may be a result of treatment.	

9	If I am unable to keep an appointment, I understand that a 24 hour notice is required, otherwise I will be charged for the time reserved.	
10	If I forget or consciously choose to forgo my appointment for any reason, I will be considered a “no show” and agree to be charged the full amount of my scheduled time.	
11	If I arrive late, my session may be shortened in order to accommodate others whose appointments follow mine. Depending upon how late I arrive, my Therapist will then determine if there is enough time remaining to start a session. Regardless of the length of time actually given I will be responsible for the full cost of the session.	

I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my Therapist and update this form before receiving additional massages. **If I am under the age of 17 I will provide written consent of parent or guardian to receive massage.**

Client Signature: _____ Date:_____

(**Parent or Guardian if under age 17)**

Therapist Signature:_____ Date:_____

TO BE COMPLETED BY MASSAGE THERAPIST

Type of Massage Techniques to be implemented	
Parts of body to be massaged	
Indications/Contraindications	