Island Glow Wellness

Massage Therapy

Personal Information

Name _____ Phone (day) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? □ yes □ no

If yes, please list name and use: _____

_____

Are you currently pregnant? □ yes □ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? □ yes □ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? □ yes □ no

If yes, please list: _____

Please indicate any of the following that apply to you.

□ Cancer
□ Headaches/Migraines
□ Arthritis
□ Diabetes
□ Joint Replacement(s)
□ High/Low Blood Pressure
□ Neuropathy
□ Sensitivity to vibration
□ Fibromyalgia
□ Stroke
□ Heart Attack
□ Kidney Dysfunction
□ Blood Clots
□ Numbness
□ Sprains or Strains
□ Pacemaker

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? □ yes □ no

What type of massage are you seeking?

□ Relaxation □ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

□ Light □ Medium □ Deep

Do you have any allergies or sensitivities? □ yes □ no

Please explain _____

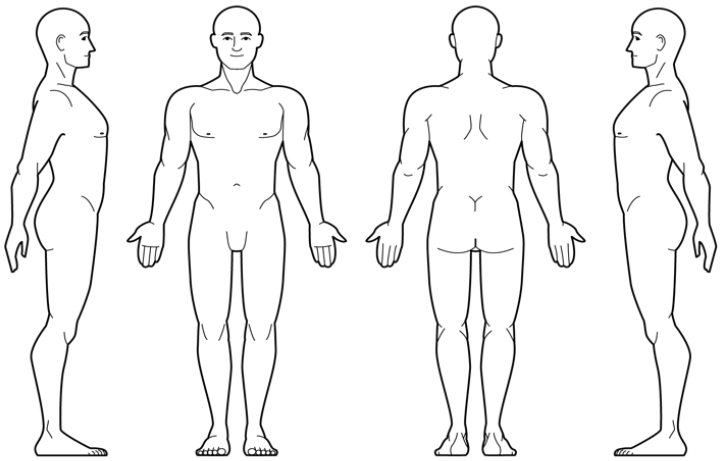
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? □ yes □ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



____ I voluntarily request and consent to receiving massage therapy.

____ I understand that the massage service offered is for the purpose of general wellness, stress reduction, and relief of muscular tension only.

____ I do not have any injuries or conditions that prevent me from receiving massage therapy. I understand the importance of informing my massage therapist of all medical conditions and medications that I am taking and that there may be additional risks based on my physical condition.

____ If I experience any pain or discomfort, I will immediately inform my therapist so that the pressure or techniques used can be adjusted to my comfort level. I will not hold my massage therapist responsible for any pain or discomfort I experience during or after the session.

____ I understand that the risks associated with massage therapy include but are not limited to:

-Superficial bruising
- Short-term muscular soreness
- Exacerbation of undiscovered injury

____ I do not have any contagious conditions that may put my massage therapist or other clients at risk.

____ I understand that I or the massage therapist may terminate the session at any time.

____ I understand that massage therapy is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware.

____ I release the massage therapist, Kacie Evans, and the business, Island Glow Wellness, from all liability for any harm that may unintentionally result from this treatment.

By initialing this Massage Therapy Consent and Release Form, the client acknowledges that they have been informed about the nature of the massage therapy they will receive and any potential risks associated with the treatment. The client affirms that they have disclosed any relevant medical conditions or concerns to the therapist and understands that

By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____