Relaxation Advantage
Massage Therapy

CLIENT INFORMATION

Name:	Date:
Address:	Referred By:
	Date of Birth:
Telephone (home)	Other Phone (cell or work)
Email:	
Occupation:	
Emergency contact and phone number:	
Primary Medical Practitioner	
What are you hoping to gain from massage? (e.g. relieve discomfort, relaxation, pain management, reduce stress)?	
Do you have any current physical discomforts? If yes, briefly describe.	
Have you ever suffered any serious injuries or trauma, been hospitalized or had surgery? If yes, briefly describe.	
Are you presently under a medical practitioner's care and/or taking medication? Allergies? If yes, briefly describe.	
Have you received professional bodywork in the past, including chiropractic/osteopathic care? If yes, briefly describe.	
Do you exercise regularly? If yes, briefly describe type and frequency?	
Please list any hobbies or activities that you participate in.	
Please list any concerns you may have that are not listed above.	

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Consent for Care

I understand that my practitionar is not a licensed MEDICAL healthcare provider.

I acknowledge that massage is not a substitute for medical care, medical examination or diagnosis and that I should see a qualified medical specialist for any mental or physical ailments that I am aware of.

I have stated all my known medical conditions. I will inform my practitioner of any changes in my health state.

It is my choice to receive massage, I am aware of the benefits and risks, and I give my consent for massage.

I understand that any sexually suggestive remakes or advances made by me will result in the immediate termination of the session and I will be liable for payment of the scheduled appointment.

I understand that the client therapist relationship will be held in strict confidence.

If I experience any discomfort during the session I will inform the therapist so that it can be addressed and adjusted to my level of comfort.

Signature: _____ Date: _____