Healing inSPArations

805 E Cedar St. * Angleton, TX 77515 * 979-849-9009

Client consent form

Required by the Texas Department of Health Services

NAME: _____ DOB:_____
ADDRESS:_____CITY, STATE & ZIP_____
HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____
EMAIL ADDRESS:_____DRIVER LIC#_____STATE_____
In Case of Emergency, notify: Name & Phone #_____

How did you hear about our office? __family, __friends, __Vision Mag., __Phone ad, __Present Clients, __Website, __internet

ARE YOU A RETURNING CLIENT OR IS THIS YOUR FIRST VISIT:_____, IF RETURNING CLIENT, HOW LONG SINCE LAST VISIT WITH US:_____

WHAT TYPE OF MASSAGE ARE YOU REQUESTING (please circle one below)

Swedish (Relaxation)*Deep Tissue/Therapeutic(deeper muscle work)*Pregnancy Massage*Hot Stone Massage*Reflexology
SPA package including Massage

Areas of pain/tension:_____
Areas to be avoided:_____

- ***The massage therapist <u>will not</u> perform breast massage on female clients without written consent of the client prior to the massage session.***
- ***Draping will be used doing massage session – only the area being worked on will be uncovered.***
- ***Clients under 17 years old MUST BE accompanied by a parent of legal guardian during the entire session.***

If uncomfortable for any reason the client (or therapist) may ask to end the massage session, and the session will be ended.

I,_____(print name) 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 this session, I will immediately inform the therapist so that the pressure and/or strokes 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 therapists are not qualified to perform spinal or skeletal 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 affirm that I have stated all my known conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

CLIENT SIGNATURE:_____DATE:_____

PLEASE DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED ONLY BY THE THERAPIST:

Type of massage techniques to be implemented: _____
Part of the body to be massaged (Including indications and contraindications:

_____
_____
_____

THERAPIST SIGNATURE:_____DATE:_____

Revised 9.8.15

Name_____ **DOB:** _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the BEST of you knowledge.

Have you had a professional massage before? _____YES _____NO
Do you have any difficulty lying on your front, back or side? _____YES _____NO
Do you have allergies to oils, lotions, or ointments? _____YES _____NO
Do you have sensitive skin? _____YES _____NO
Are you wearing contact lenses _____, dentures _____, a hearing aid _____?
What is your daily routine? _____
Do you perform any repetitive movements throughout the day? _____
Do you feel you experience stress throughout the day? _____
Where are you experiencing discomfort, tension, of stiffness? _____
Do you have a particular goal in mind for this massage session? _____
Are you currently under medical supervision? _____YES _____NO
Are you pregnant? _____YES _____NO, IF YES, how far along are you? _____
Have you had any Medical changes since your last visit to our office? _____YES _____NO, IF YES, please list below any changes to health or medication that you have.

_____
_____
_____

Please check any condition listed below that applies to you:

() contagious skin condition
() open sores or wounds
() easy bruising
() recent accident, injury, fracture, surgery
() artificial joints
() sprains/strains
() current fever
() swollen glands
() allergies/sensitivity
() heart condition
() high/low blood pressure
() circulatory disorders
() varicose veins
() atherosclerosis
() phlebitis
() deep vein thrombosis/ blood clots
() joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
() osteoporosis
() epilepsy
() headaches/migraines
() cancer
() diabetes
() decreased sensation/numbness
() back/neck problems
() fibromyalgia
() TMJ
() carpal tunnel syndrome
() tennis elbow

_____ _____
Client signature Date

_____ _____
Technician Signature Date

Revised 9.8.15