

Massage Consent Form

Name(please print)_____ Date_____

Have you ever had a massage before? Y N When?_____

Are there any areas of your body you would like to focus on or be avoided?

Are there any current conditions that we should be aware of? _____

May we contact your doctor if we need to consult him for safety? Y N

Are you currently taking ANY medications/supplements/herbs? Y N

If so, please list _____

Have you ever had any form of cancer? Y N

If yes, please list the type, dates, and current status _____

Have you had any major surgeries/injuries that we should be aware of? Y N
Please list the date(s) and current status _____

Please indicate if you currently or in the recent past have had the following:

Diabetes Asthma Communicable Diseases
 Difficulty sleeping Allergies High/Low Blood Pressure
 Skin Conditions Headaches/Migraines

Please indicate your areas of discomfort/what you would like us to focus on:

By signing below I declare that, to the best of my knowledge, the above information is accurate and truthful. According to informed consent, I acknowledge that I am aware of the possibility of soreness following the massage. I am also aware that any massage will be NON-sexual in nature. At any time the therapist or client feels uncomfortable the massage may be terminated immediately.

Client Signature

Thank You!