Personal Information

Full Name:_____ **Date:**_____ **Date of Birth:**_____

Email:_____ **Phone:**_____

Address:_____ **City:**_____

State:_____ **Zip Code:**_____ **Occupation:**_____

Emergency Contact:_____ **Number:**_____

Relationship:_____ **How did you hear about us?:**_____

Medical Information

Check all that apply to you:

- ☐ Headaches/Migraines
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Pain
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains/Strains
- ☐ Stress
- ☐ Sinus Problems
- ☐ Varicose Veins
- ☐ Knee Problems
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Heart Problems
- ☐ Circulatory Problems
- ☐ Sciatica
- ☐ Skin Rashes
- ☐ Carpal Tunnel
- ☐ Tendonitis
- ☐ Allergies
- ☐ TMJ

Pregnant? ____**YES** ____**NO**

If yes, how far along? _____

List any and all medications currently being taken:_____

List any injuries, accidents or surgeries:_____

List all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:_____

Explain any areas noted above:

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MARRIAGE THERAPY

Massage Information

Have you had a professional massage before?

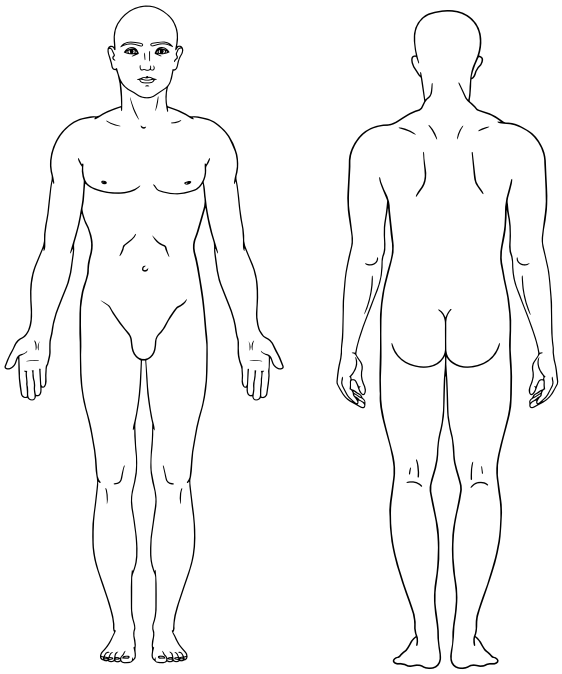
__YES __NO

Is there any area you want avoided during the massage?

What pressure do you prefer?

_____LIGHT _____MEDIUM _____DEEP

Please describe your goals for the session:



Circle any areas of discomfort.

Client-Practitioner Statements

Please read and initial next to each statement to signify you understand.

____ I hereby give consent for Refresh Massage Therapy to provide massage therapy services.

____ I understand that massage therapy may provide benefits for certain conditions which may include relief of muscular tension, relaxation, improvement of circulation, reduction in the symptoms of stress-related conditions and provision of general wellbeing, but results are not guaranteed.

____ I understand that the side effects of massage therapy may include muscle soreness, mild bruising, increased areas of pain, swelling and light-headedness amongst other possible temporary outcomes.

____ I will advise the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly. I will not hold my therapist responsible for any pain or discomfort during or after my session.

____ I understand that the level of undressing is up to me, however I will be draped modestly and appropriately the entire massage.

____ I understand that any sexual overtures, innuendos, language or behavior will result in termination of massage and the police to be called. There will be no refund in this instance.

____ I understand that I have the right to question procedures used and to receive an explanation of any treatments given by the therapist.

____ I understand that I have the right to terminate the session at anytime without reason.

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Cancellation Policy

Please read and initial next to each statement to signify you understand.

_____ I understand that if I need to reschedule, I should contact Refresh Massage Therapy 24 hours in advanced so the business is able to attempt to fill the appointment time. Failure to contact before 24 hours of appointment time will result in late cancel fee of 25% of cost.

_____ I understand that not showing up to scheduled session and failing to contact Refresh Massage Therapy will result in a cancellation fee of 50% of cost.

_____ I understand that if a late cancel or no show fee is still remaining, I will be unable to schedule another appointment with Refresh Massage Therapy until remitted.

_____ I understand showing up late will shorten the time of the session and time lost will not be subject to refund.

If you have any questions regarding any policies listed on this form, please let us know and we will be happy to clarify.

Parental Consent

I hereby confirm that all information on this form is accurate. I acknowledge that my child is under the age of 18 years and by signing this parental consent form, I am agreeing to have Refresh Massage Therapy perform massage therapy on my child/dependent.

Parent/Guardian (printed)_____Signature_____Date_____

Client Consent

I hereby confirm that all information on this form is accurate. I confirm that I am at least 18 years of age and by signing this consent form, I agree to waive all liability towards my therapist and Refresh Massage Therapy for any injuries or damage incurred due to any misrepresentation of my medical history.

Client (printed)_____Signature_____Date_____

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