Dr. K's Med Spa
Wellness and Rejuvenation

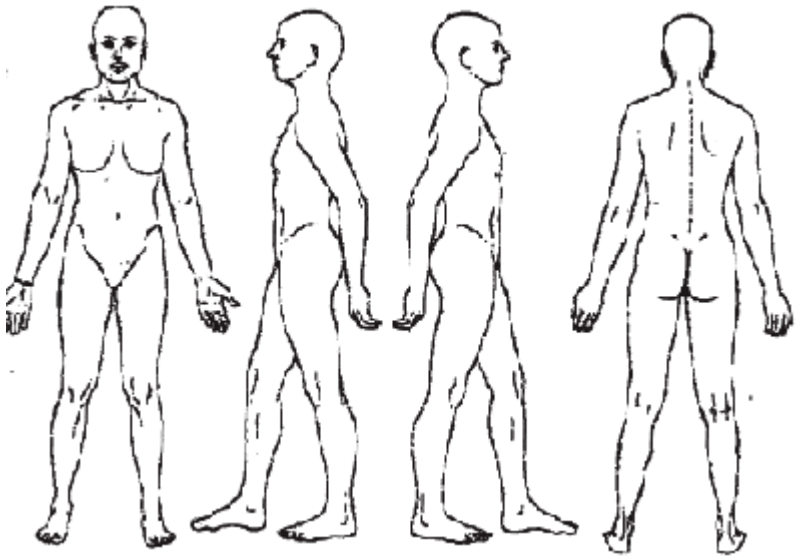
Massage Consent Form

Please answer the questions to the best of your knowledge. **Date**_____

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy?
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain._____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
   If yes, please explain._____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain._____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain._____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, how do you think it has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?
   Yes No If yes, please identify_____
10. Do you have any particular goals in mind for this massage session? Yes No
    If yes, please explain._____

Check any specific areas you would like the Massage Therapist to concentrate on during the session:

___ Phlebitis
___ Deep vein thrombosis/blood clots
___ Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
___ Osteoporosis
___ Epilepsy
___ Headaches/migraines
___ Cancer
___ Diabetes
___ Decreased sensation
___ Back/neck problems
___ Fibromyalgia
___ TMJ
___ Carpal tunnel syndrome
___ Tennis elbow
___ Pregnancy
If yes, how many months? _____



Medical History

11. Are you currently under medical supervision? Yes No
    If yes, please explain._____
12. Do you see a chiropractor? Yes No If yes, how often?
13. Are you currently taking any medication? Yes No
    If yes, please list._____

14. Please check any condition listed below that applies to you:

___ Contagious Skin Condition
___ Open Sores or Wounds
___ Easy Bruising
___ Recent Accident or Injury
___ Recent Fracture
___ Recent Surgery
___ Artificial Joint
___ Sprains/strains
___ Swollen Glands
___ Allergies/sensitivity
___ Heart Condition
___ Circulatory Disorder
___ Current Fever
___ High or Low blood pressure
___ Varicose Veins
___ Atherosclerosis

Please explain any condition that you have marked above.

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I,_____, 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 medical 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.

Signature of Client _____ Date _____

Signature of Massage Therapist _____ Date _____