



M A S S A G E
T H E R A P Y



Tani Gray

MASSAGE THERAPY CLIENT INTERVIEW

Name: Tess Ling Date: _____

Occupation: DOB ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ Post Code: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

Would you like to be added to our email list for news and exclusive offers?

Yes ☐ No ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis / joint disorder | <input checked="" type="checkbox"/> Easy bruising | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Artificial joint | <input checked="" type="checkbox"/> Eczema | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Atherosclerosis | <input checked="" type="checkbox"/> Epilepsy | <input type="checkbox"/> Recent accident/injury |
| <input type="checkbox"/> Blood disorder | <input checked="" type="checkbox"/> Fever blisters | <input type="checkbox"/> Recent fracture |
| <input type="checkbox"/> Back/neck problems | <input checked="" type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Cancer | <input checked="" type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Skin disease/lesions |
| <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Contagious skin condition | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Decreased sensation | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Open sores or wounds | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose veins |

Any other illness/condition: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes: _____

Any current medications? _____

Any medical treatments? _____

MESSAGE THERAPY

CLIENT INTERVIEW

Have you had a professional massage before? ☐ No ☐ Yes

Do you have any difficulty lying on your front, back, or side? ☐ No ☐ Yes

Do you have sensitive skin? ☐ No ☐ Yes

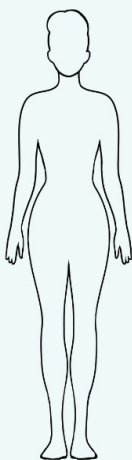
Do you have any allergies including oils or lotions? ☐ No ☐ Yes

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

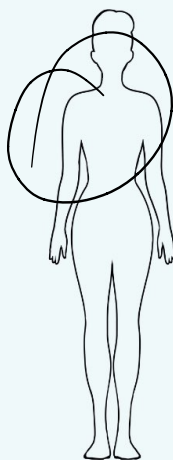
What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas you do not want massaged? ☐ No ☐ Yes

Mark any specific areas you would like your therapist to concentrate on:



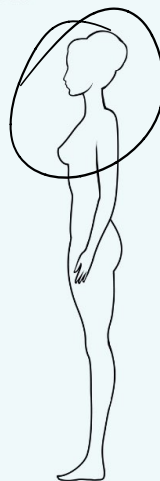
Front



Back



Right



Left

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 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.

M A S S A G E T H E R A P Y

YGT CONSENT FORM

Client Name: _____

Massage therapy is a profession in which the practitioner applies manual techniques, and may apply adjunctive therapies, with the intention of positively affecting the health and well-being of the client.

Massage Therapists do not diagnose or prescribe for medical conditions nor are they allowed to provide treatment for a specific condition without a doctor's supervision. The massage therapist is required to refer you for diagnosis and to follow recommendations of your physician. The massage therapist is happy to adjust pressure, temperature & technique if you request it.

It is the responsibility of the client to keep the massage therapist informed of any medical treatment currently being taken, and to provide written permission from the physician, chiropractor, physical therapist, etc., that the massage may be continued. The client must also keep the massage therapist informed of any changes in health conditions.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment of which I am aware.

I have stated all my known medical conditions, and answered all questions honestly.

I will keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist should I fail to do so.

This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

I understand the Massage Therapist reserves the right to refuse services to me for any reason that they deems necessary.

My signature acknowledges that I have read and agree with the above conditions.

I agree to receive the massage therapy and I will adhere to all of the aforementioned statements above.

_____	_____	_____
Client Name (printed)	Client Name (signature)	Date

Therapist (signature)		Date