



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



Tani Gray

MASSAGE THERAPY CLIENT INTERVIEW

Name: Tess Ting Date: _____

Occupation: DOB ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ Post Code: _____

Phone: _____ Email: _____

Emergency contact: Ian Gray 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:

☐ Arthritis / joint disorder

☒ Easy bruising

☒ Phlebitis

☐ Artificial joint

☒ Eczema

☐ Pregnant

☐ Atherosclerosis

☒ Epilepsy

☒ Recent accident/injury

☐ Blood disorder

☒ Fever blisters

☒ Recent fracture

☐ Back/neck problems

☒ Fibromyalgia

☐ Seborrhea

☐ Cancer

☒ Headaches/migraines

☐ Seizure disorder

☐ Carpal tunnel syndrome

☐ Heart condition

☐ Skin disease/lesions

☐ Circulatory disorder

☐ High/low blood pressure

☐ Sprains/strains

☐ Contagious skin condition

☐ Immune disorders

☐ Swollen glands

☐ Decreased sensation

☐ Keloid scarring

☐ Tennis elbow

☐ Deep vein thrombosis

☐ Open sores or wounds

☐ TMJ

☐ Diabetes

☐ Osteoporosis

☐ Varicose veins

Any other illness/condition: _____

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

Any current medications? _____

Any medical treatments? _____

MASSAGE 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?

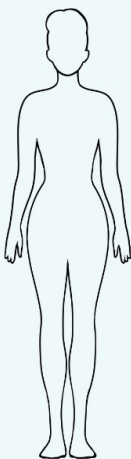
☐ Light

☒ Medium ☐ Deep

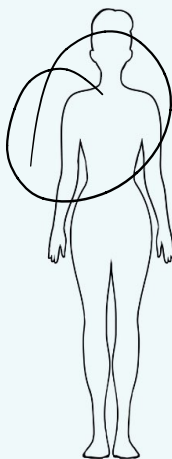
Are there any areas you do not want massaged?

☐ No ☒ Yes

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



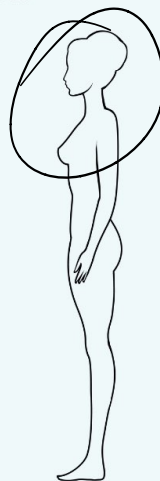
Front



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: _____

~~TOSS~~ TING

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)

30.6.25

Date

Therapist (signature)

Date