Suzi's Skin Care Studio LLC.

Massage Consent Form

Swedish_____ Deep Tissue_____ Cupping_____ Hot Stone_____

Name_____Phone:_____Referred by:_____

Address _____City:_____State/Zip_____

Date of Birth_____Male/Female_____E-mail_____

Emergency Contact_____ Cell #_____Occupation:_____

Have you ever received Massage Therapy before?

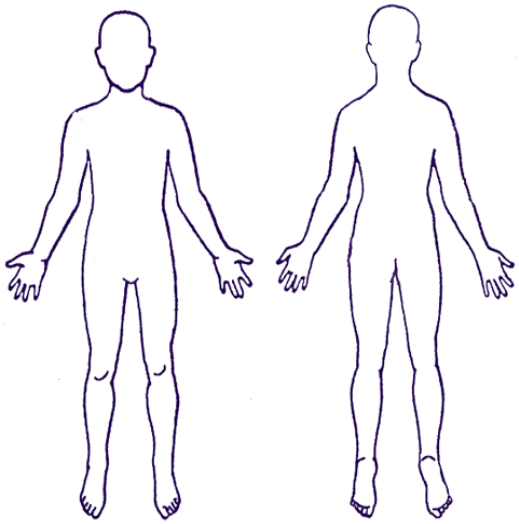
Yes No

Type of Massage received:

Deep Tissue Swedish Hot Stone Other

Indicate with an (X) the places you are feeling discomfort.

Front Back



Do you have a history of the following:

___accident

___neck pain

___whiplash

___headaches

___disc problems

___mid back pain

___low back pain

___joint ache

___decreased range of motion

___abdominal pain

___broken bones

___sprains

___seizures

___nervous tension

___arthritis, gout or bursitis

___surgery

___lung or breathing problems

___breast augmentation

___diabetes

___varicose veins or blood clots

___high blood pressure

___stroke

___colitis

___heart attack

___cancer

Indicate any of the following that apply to you today:

____Sun

____inflammation

____Severe pain

____headache

____open cuts/bruises, burns

____irritated skin rash

____ Cold/ flu

____Contacts/ other prosthesis

____Pregnancy

Please list all medications below:

Please write below any other information you think the therapist should know.

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Areas of persistent tension of pain:

Primary reason for appointment:

Other conditions the massage therapist should know about:

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, reduction of scar tissue or chronic pain and for the promotion of circulation, lymph activity, flexibility, and proprioception.

I understand that a massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulation. It has been made very clear to me that this massage therapy is not a substitute for medical examination and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I may have.

A massage therapist must be aware of existing physical conditions, hence I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature: _____ Date: _____