Last Name:_____ First:_____ Mi:_____

Address:_____
Appt/# Street City Prov Postal code

Cell phone: _____ E-mail :_____

Date of Birth: _____ Emergency contact:_____
mth / day / year Name Phone #

Occupation: _____

How did you hear about us? □ Facebook □ Instagram, □ Google , other : _____

How often do you receive massage? 1x per week, □ 1x per month, □ 2x per month; other: _____

When was your last massage? _____How often would you like to receive massage?_____

Reasons for appointment: □ STRESS, □ RELAXATION, □ HEADACHE, □ SPORTS RELATED PAIN, □ GENERAL PAIN RELIEF
□ OTHER:_____

Desired Pressure: □ **light,** □ **firm,** □ **deep**

What type of physical activity do you engage in frequently? □ tennis, □ running, □ cycling, □ golf, □ gym,
□ swimming, □ hiking, □ horse riding, other:_____

Check all that apply:

□ Epilepsy/Seizures □ Cancer □ **Pregnant** □ Contagious diseases, □ Stroke
□ Heart problems □ Artificial Limbs, Metal Plates , screws □ Broken bones in the past two (2) years
□ Accidents or injuries in the past two (2) years □ Surgery □ Taking medication(s) □ Tumors

If you check any of the above, please explain as clearly as possible in the comments space provided below.

Comments:_____
_____
_____

□ Diabetic
□ Migraines
□ Sciatica
□ Arthritis
□ Skin problems
□ Tension
□ Clots
□ Low Blood Pressure

□ Back pain
□ Hypothyroid
□ Numbing
□ Bruise easily
□ Stabbing Pains
□ Joint Swelling
□ Rheumatoid Arthritis
□ Fibromyalgia

□ Stress
□ Circulatory problems
□ Varicose veins
□ Anemia
□ Carpal Tunnel
□ Soreness
□ Cyst
□ AIDS

□ High blood pressure
□ Headaches
□ TMJ
□ Osteoporosis
□ Allergies
□ Insomnia
□ HIV
□ Sensitive to touch or pressure anywhere

□ **Other:** _____

Your Therapist will indicate if a Physician's Permission Form will be needed prior to receiving your service.

Are you comfortable having your Therapist massage the following?

□ Feet, □ Face, □ Scalp, □ Abdomen, □ Gluteal Region (Buttock)

Please read the following statements, then sign below on Page 2!

I am aware that draping will be used during the massage session and I understand that it is not within the scope of the massage session for the Therapist to engage in breast massage. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I am to bring it to the Therapist's attention and request that the session end or be altered.

The massage treatment given at Massage Haven is for the sole purpose of stress reduction, relief from muscle tension or spasm, and to increase circulation and energy flow. The Therapists at Massage Haven do not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder. Nothing said during the session should be construed as such. The Therapists do not do spinal manipulations. Massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.

It is important to disclose any use of medication or drugs (medicinal or recreational) and any other Mind/Body altering substances before Treatment, with the understanding that your Treatment may be refused by the Therapist to avoid any harm to you, the client.

It is the Client's (you) responsibility to explain and discuss all physical conditions with the Therapist so that the Therapist may do their job. Your Therapist is solely responsible for your treatment.

I agree to hold Massage Haven, its Therapists, or any individual at said institution free of any responsibility as to my physical condition before or after having received the usual and customary massage service offered by said institution, whether said service is one or more than one.

I agree not to utilize the service of Massage Havens Therapists except on Massage Havens premises.
I have read and fully understand this form in its entirety. If at any time there are changes to the information given, or in my condition, I will notify my Therapist, and update this form before receiving additional services.

By providing your email, you consent to receiving receipts, important updates and newsletters.

Client Signature Date **Therapist Signature** Date

Consent to Treatment of Minor: By my signature below, I hereby authorize Massage Haven Therapist to administer massage therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian Age of minor sex Date