Name:

Address: City: State: Zip:

Home Phone#: Work: Cell:

Occupation:

Physician:

Age: Date of Birth: Referred by:

Primary Reason for Appointment:

Email Address:

Please take a moment to carefully read the following information and sign where indicated. If you have a sp
condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary c
be required prior to service being provided.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you have a thyroid condition?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from arthritis?

Yes No Are you wearing contact lenses or dentures?

Yes No Do you have cardiac or circulatory problems?

Yes No Do you have high blood pressure and/or take medication to manage blood pressure?

Yes No Do you suffer from epilepsy or seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you have varicose veins?

Yes No Do you have any contagious diseases?

Yes No Do you have osteoporosis?

Yes No Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)?

Yes No Do you bruise easily?

Yes No Any broken bones in the past two years?

Yes No Any injuries in the past two years?

Yes No Do you suffer from back pain or disk herniation?

Yes No Do you have numbness or stabbing pains?

Yes No Are you sensitive to touch or pressure in any area?

Yes No Have you ever had surgery?

Yes No Other medical condition, or are you taking any

Yes No Have you ever experienced a professional massage or body work session? How recently?____

Comments____

____

I,______________________________, understand that massage/bodywork I receive here is provided for th
basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or disc
during this session, I will immediately inform the practitioner/therapist so that the pressure and /or strokes m
adjusted to my level of comfort.

I further understand that massage/bodywork should not be construed as a substitute for medical examinatio
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 do not expect massage therapy to correct any malig
conditions nor do I hold Massage Academy of the Poconos, LLC and/or all persons under it's control
and supervision liable for any future spreading of a malignant condition.

I understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustment
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/bodywork is contraindicated (should not be done) under certain medical conditions, I affi
that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep th
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 forget to do so.

It is also understood 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 "full" scheduled appointment.

Signature: Date:
____

Therapist's Signature: Date:
____

Consent to Treatment of Minor: By my signature below, I hereby authorize Massage Academy of the Pocon
administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necess

Signature of Parent or Guardian____ Date _________