



Massage Consent Form

Name:	
Phone: Cell:	Home:
Work:	
Address:	City, Province, Postal Code:
Email:	
Date of Birth (MM/DD/YYYY):	Gender: Male / Female
Occupation:	
Emergency Contact Name & Phone:	
How did you hear about us:	
Can we contact you through email with appointment reminders? <input type="checkbox"/> No <input type="checkbox"/> Yes	Text Appointment Reminders? <input type="checkbox"/> No <input type="checkbox"/> Yes
Email special promotions? <input type="checkbox"/> No <input type="checkbox"/> Yes	

General Health

1. What medications are you currently taking (Prescription / Over the counter) ?

2. Do you have any allergies? No Yes. If yes, please list:

3. Please list all previous surgeries (please indicate date):

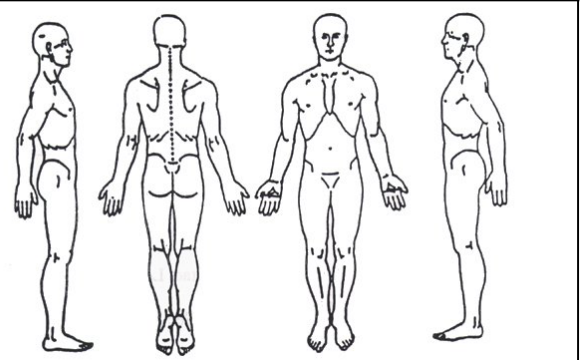
4. Do you have any of the following health conditions:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Falls or injuries	<input type="checkbox"/> Liver Condition	<input type="checkbox"/> Kidney/Bladder
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Skin Condition

Other (please explain):

5. Are you pregnant? No Yes. If yes, when is your expected due date?

6. Any special notes or instructions for the massage therapist regarding your treatment today?



Please mark on diagram where you feel any pain or discomfort

Client Consent and Signature

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I consent to the treatment being undertaken and I hereby indemnify Serene Escapes Day Spa and its Owners & Staff from any claims whatsoever. I understand that Massage Therapy is not a substitute for medical examination as it is recommended to follow up with my family physician. It is also my responsibility to inform Serene Escapes Day Spa of all changes to my medical history that may affect my treatment. All information is solely collected for the internal use of Serene Escapes Day Spa and will not be shared with any third parties.

Client Signature

Date

Parent / Guardian Signature (if Client is under 18)

Date