WELLNESS SOLUTIONS

MASSAGE THERAPY CLIENT INTAKE AND TREATMENT CONSENT FORM

All information is kept strictly confidential as required by Federal Law.

Full Name: _____ Date: _____

Occupation: _____ Birthdate: _____

Phone: _____ Email (optional): _____

Address: _____

How did you hear about us? _____

Have you had a professional massage session before? ☐ Yes ☐ No

Are you currently being treated by a doctor for an illness? ☐ Yes ☐ No
If YES, please list reasons and treatments: _____

_____

List all medications and supplements you are currently taking: _____

_____

Are you experiencing any of the following today? Please check all that apply:

☐ Fever	☐ Cold/flu	☐ Open cuts/ skin rash/ new tattoo
☐ Severe pain	☐ Recent surgery	☐ Alcohol intake in the past 24 hrs
☐ Broken bones	☐ Sprained muscles	☐ Strong emotional distress
☐ Headache	☐ Anything contagious: _____	

Are you experiencing physical pain today? If YES, please explain: _____

_____

Massage may be contraindicated or needs to be modified in certain conditions. Have you been diagnosed with any of the following? Please check all that apply:

☐ Arthritis	☐ Blood clots	☐ Cancer	☐ Diabetes	☐ Disk herniation
☐ Heart disease	☐ Immune dysfunction	☐ Seizures	☐ Stroke	☐ Varicose veins

Please list all your surgeries: _____

_____

Do you experience allergic reactions to any of the following? (Please check all that apply)

☐ Environmental	☐ Nut products	☐ AC/forced air heat
☐ Essential oils	☐ Cosmetics	☐ Other: _____

Are you pregnant? ☐ Yes ☐ No If YES, how many weeks: _____

Please read and sign the Informed Consent Form on the following page.

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INFORMED CONSENT FORM
Wellness Solutions LLC, A Healing Arts Studio

I understand that massage therapy is not a substitute for medical examination, diagnosis, or treatment of an illness. Massage therapists are not licensed to perform skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and anything said in the course of the session should not be construed as such.

I understand that my feedback is essential for a safe and effective massage treatment. If something hurts or feels uncomfortable, I will let the therapist know as soon as possible.

The following sometimes can occur during a therapeutic massage as a normal response to relaxation: the need to shift position, sighing, yawning, stomach gurgling/gas, emotional feelings release, daydreaming or falling asleep.

I have stated all of my known medical conditions and answered all the questions honestly and to the best of my ability.

Draping will always be used, but I am aware that clothing can be left on if I prefer to do so.

If anything changes in the information provided to Wellness Solutions, I will notify the therapist and update this form before receiving another massage treatment. I understand that results are not guaranteed. I understand that the massage therapist is not responsible for any complications that may arise from massage exercises.

I understand that a record will be kept on my personal information and the services provided. This record will be kept confidential and will not be released to others unless so directed by myself or unless the law requires it.

I understand this Consent Form and intend this form to cover the entire course of treatment with Wellness Solutions LLC and its associated massage therapists. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. The massage treatments I receive at Wellness Solutions LLC are voluntary. I release Wellness Solutions LLC from full liability and assume full responsibility thereof.

By my signature, I confirm all of the above and give my consent to receive massage therapy.

Name Printed: _____ Signature: _____

Signature of Guardian: _____ Date: _____

Massage Therapist Signature: _____ Date: _____

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