Print Form

Golden Tranquility Massage Therapy

Thank you for your interest in Massage Therapy.
Please fill out the information below and give your completed form to your Massage Therapist.

Name: _____ **Telephone:** _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State/Zip:** _____
E-mail: _____
Emergency Contact: _____ **Telephone:** _____

How did you hear about Golden Tranquility?
Referral (by whom?) _____ **Other:** _____

General & Medical Information:
Occupation: _____ Age: _____ Gender: _____
Health Insurance Carrier: _____ Physician: _____

Have you ever experienced a professional massage or bodywork session? (Y/N) _____
If yes, when? _____

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

If you are experiencing any of the following, please explain in the space provided.

Acne	AIDS
Allergies	Arthritis
Asthma	Athletes Foot
Back problems	Blood Clots
Bruise Easily	Cancer or Tumors
Contact Lenses	Dentures
Diabetes	Eczema
Epilepsy or Seizures	Fibromyalgia
Fractures	Glaucoma
Headaches – frequency/type?	
Heart Disease	Herpes
High Blood Pressure	Hives or Shingles
Impetigo	Kidney Disease
Knee problems	Lung Disease
Neurological Disorders	Numbness or Tingling
Osteoporosis	Plantar Warts
Pregnant or Nursing	Psoriasis
Rashes	Stroke
Thyroid Disorder	Varicose Veins
Do you have any contagious disease(s)?	
Other	

Are you currently suffering from any ailment that could be affected by today's massage? If yes, please explain:_____

_____

If yes to the previous question, are you currently under doctor's supervision for this ailment? Please explain:_____

_____

Have you had any broken bones, surgery, injuries, or accidents in the past two years? If yes, please explain:_____

_____

Are you currently taking any medication? If yes, please explain:_____

_____

Do you have any tension or soreness in a specific area? Please specify:_____

_____

Do you have cardiac or circulatory problems? Please explain:_____

_____

Are you currently seeing a chiropractor, physical therapist, or physician for an ongoing issue? If yes, please explain:_____

_____

Are you sensitive to touch or pressure in any area? If so, what area?_____

_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of this session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapists part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by myself and/or the massage therapist will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____

Massage Therapist Signature_____ Date_____