Aluvia's Massage Therapy

Consent for Treatment

Name_____ DOB_____ Today's Date_____

Town of Residence_____

Best phone # (H)_____ (C)_____(O)_____

Email _____

Emergency Contact: _____ Phone:_____

A massage therapy appointment is provided for the basic purposes of **relaxation and reduction of muscular tension.** I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe or treat any medical condition. If I have a specific medical condition, massage may be **contraindicated** and a letter of approval from my primary care provider may be necessary prior to the session.

If I experience any **pain or discomfort**, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I also understand that massage should not be construed as a substitute for medical diagnosis or treatment and should **see a physician** or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that the therapist uses **draping**, and will not massage the breast or genital areas. Both therapist and client reserve the right to immediately **discontinue a session** or decline future treatments due to any inappropriate behavior.

I affirm that I have stated all of my known **medical history** and agree to keep my massage therapist updated to any changes in my condition, and that there shall not be any liability on the therapist's part should I forget to do so.

I understand that it is best not have alcohol, stimulants or recreational drugs **24 hours prior to a massage**.

I am aware that I may incur the cost of the session without **24 hours cancellation notice.**

Signature _____ Date_____

Aluvia's Massage Therapy
Client Intake Form

Aluvia enhances Swedish Massage with energy balancing, and includes Body Movement Therapy, Aromatherapy and Music based on your preferences.

Occupation _____

Do you sit at a desk the majority of the day?_____

Do you drive more than 30 minutes to work?_____ How long is your commute?_____

Circle Stress Level: High Average Low None

When did you last have a massage?_____

What is your goal for today's visit (relaxation, pain relief, etc) _____
___

***Please indicate presence of any of the following conditions**:*

__Cardiovascular
__High or Low Blood Pressure
__Liver, Kidney, or Digestive
__Respiratory
__Cancer or Tumors
__Fibromyalgia or Chronic Fatigue
__Stroke
__Impaired Immune System
__Rheumatoid/Osteoarthritis
__Neurological(Parkinsons, MS, Seizures)
__Diabetes
__Swelling/Lymphodema
__Numbness
__Headaches

Are You Pregnant-If yes, how many weeks____ First pregnancy?_____

Please List Any Allergies:_____

Please list any recent injuries, surgeries, or illnesses:_____
_____
_____

What kind of exercise and how often?_____
_____

Please circle any areas of discomfort: