

The Medical Spa @ GMG

Massage Therapy Services Consent Form

Confidential Client Information:

Name: _____ Date of Birth: _____

Address: _____
City State Zip

Phone: H _____ C _____ W _____

Employer: _____ Occupation: _____

In Case of Emergency: _____ Contact Number: _____

Referred By: _____

Reason for Visit: _____

Please state any **Past** or **Present** injuries, accidents, or medical treatments:

Do you currently have any of the following conditions: (Please Circle)

Neck / Spine Injury	High Blood Pressure	Liver Ailment	Cancer
Back Pain	Low Blood Pressure	Kidney Ailment	Diabetes
Sciatica / Leg Pain	Skin Disorders	Heart Ailment	Headache
Carpal Tunnel	Infectious Disease	Fibromyalgia	Arthritis
TMJ Syndrome	Cold / Flu/ Fever	PMS Syndrome	Pregnancy
Sports Injury	Varicose Veins	Grief Process	Joint Pain
Breathing Disorder	Stress at Work	Stress at Home	Osteoporosis
Other _____			

Are you currently under the care of a physician? _____ If so, whom: _____

Please list the reasons: _____

Please list any medications taken now or at regular intervals _____

Do you exercise? _____ If yes how does that make you feel? _____

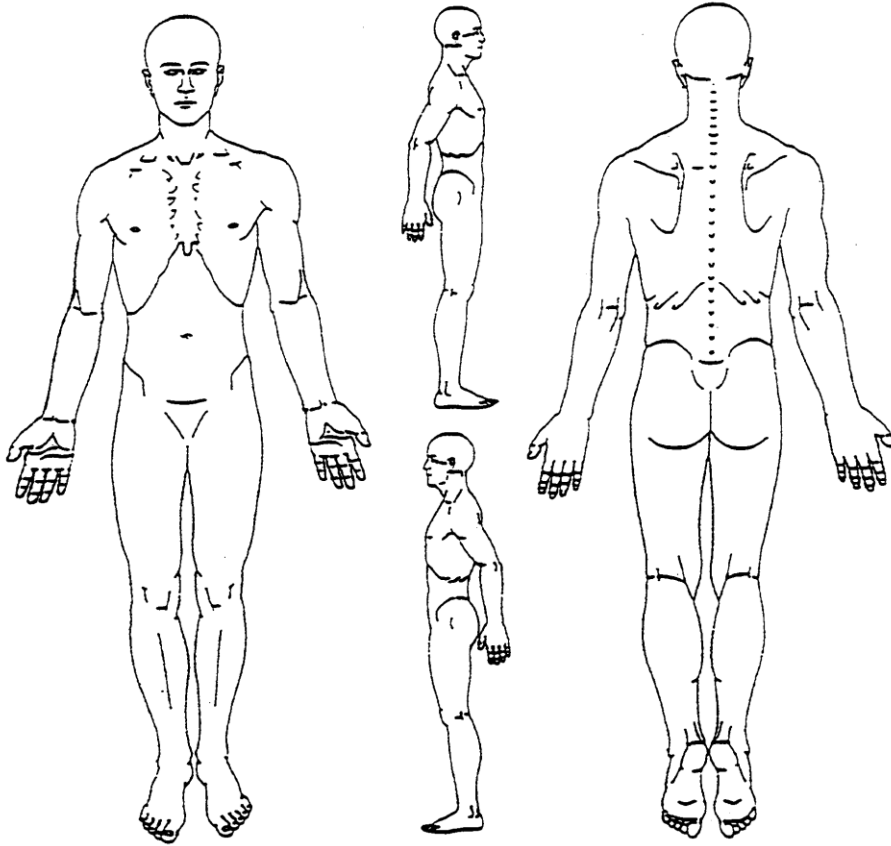
What do you do for relaxation? _____

The above information is true and accurate to the best of my knowledge. I agree to update my therapist on any changes that occur with my health. I understand that massage therapist do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination.

Signature: _____ Date: _____

Patient Name: _____ Date: _____ Chart #: _____

On the following, please indicate the problem areas and the sensation: Pain, Numbness, Tingling, Stiffness, etc.



Currently are you experiencing any of the following conditions:

- Cold or Flu
- Fever
- Contagious Disease: _____
- Infection: _____
- Open Wounds / Sores: _____
- Inflammation: _____

Comments:

Signature: _____ Date: _____