Massage Therapy Consent Form
Your answers to the questions on this form are essential to a safe, effective massage therapy session. Please take time to answer in detail and return to us 24 hours before your session.

Name: _____________________________ DOB: ____ Sex: M/F Date: ____________

E-mail Address: _______________________________ Occupation: ________________________

Address:____ City:________________ State:_____

Phone: ( )_________________________

Emergency Name and phone:
____

Radiation Oncologist: ____

Medical Oncologist: ____

Primary Cancer, Stage, Location: ____
Previous Cancer or Secondary Cancer: ____
Do you have and metastasis (spreading of the cancer)? Y/N Where? ________________________

Treatment

Have you had cancer surgically removed? Y/N Date:____
Were lymph nodes removed? Y/N How Many? ___________ Where? ________________
Have any of your health care providers expressed a concern about Lymphedema? Y/N
Has anyone explained to you what Lymphedema is? Y/N Who: _____________________________

Radiation Therapy: Completed or Undergoing? How many treatments: ______________________
Side Effects: ____

Chemotherapy? Y/N Completed or Undergoing? Date of last treatment: ___________________
Side Effects: ____
Blood Transfusion in the last 3 months? Y/N When? ______________________________________

Is your treatment for Cancer on hold for any reason? Y/N Why? ____________________________

Blood Clots

Have you ever experienced a blood clot or DVT (Deep Vein Thrombosis)? Y/N
If yes, please explain: ____
Are you currently taking blood thinners? Y/N

Medical History (check all that apply)

___ Heart Disease	___ Parkinson's Disease	___ Seizures
___ Muscular Dystrophy	___ Cerebral Palsy	___ Open Wound's
___ Multiple Sclerosis	___ Shingles	___ Crohn's Disease
___ Asthma	___ Irritable Bowel Syndrome	___ Nausea
___ Fibromyalgia	___ Diabetes	___ Bone Mets
___ Emphysema/COPD	___ Stroke	___ Joint Replacement
___ Neuropathy	___ Constipation	___ Peg Tube
___ Depression	___ Broken/Fractured Bones	___ Shunt
___ Pacemaker	___ Joint Stiffness/Swelling	___ Rods/Pins
___ Surgical Drain	___ Spasms/Cramps	___ Diarrhea
___ Disk Reconstruction	___ Anxiety	___ Osteoporosis
___ Scoliosis	___ PTSD	___ Ports/Pic Line
___ Paralysis	___ Implants	___ Oxygen Tank

Surgeries

____
____
____
____
____

Medications

List all medications you are currently taking including prescribed, over-the-counter, and herbal/nutritional supplements

____
____
____
____

Pain

Do you have any areas of pain? Y/N Where? ______________________________________
What is the reason for your pain? ____
Is this new pain? Y/N
Is your physician aware of this pain? Y/N

Activity Level

In general, what is your activity level?

___ Bed Rest	___ Sedentary	___ Occasional exercise
___ Regular exercise	___ Daily exercise	___ Competitive athlete

Are you pregnant? Y/N If yes, how far along are you? ____________________________

What kinds of physical activities do you engage in regularly?

____
____
____
____

Allergies

Do you have any allergies to latex, lotions, oils, or foods? Y/N

____
____
____
____

Massage History

Have you ever had a massage before? Y/N

What specific things did you like or not like about previous experiences?

____
____
____

Are there areas you would like to focus on during this massage?

____
____

What type of pressure would you prefer? Light, Medium, Firm

Individual who completed questionnaire? Patient or Caregiver

ACKNOWLEDGEMENT

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 or the session discontinued. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have answered all questions completely and honestly. If any medical condition changes after I begin the massage therapy sessions, I understand it is my responsibility to notify my massage therapist. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist(s), Touch of Lavender LLC (DBA The Art of Touch Therapeutic Massage) or their affiliates should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist will be responsible for determining the type of massage that is appropriate for my

medical condition as indicated by my responses above. By signing below, I am consenting to massage therapy and acknowledge that I have received and red the list of contraindications.

Client Signature ____ Date ______________

Witness Signature ____ Date ______________

Massage Therapist's Signature ____________________________________ Date ______________