

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:				
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 t	he cancer)? Y	/N Where?		
<u>Treatment</u>				
Have you had cancer surgically removed? Y	/N Date:			
Were lymph nodes removed? Y/N How I				
Have any of your health care providers exp				
Has anyone explained to you what Lymphe	dema is? Y/i	v wno:		
Radiation Therapy: Completed or Undergo Side Effects:	_	_		
Chemotherapy? Y/N Completed or Under				
Side Effects:	N When?			
Is your treatment for Cancer on hold for an	y reason? Y/	N Why?		

Blood Clots

Have you ever experienced a blood clot or DVT (Deep Vein Thrombosis)? Y/N If yes, please explain:						
Medical History (check all that apply)						
Heart Disease Muscular Dystrophy Multiple Sclerosis Asthma Fibromyalgia Emphysema/COPD Neuropathy Depression Pacemaker Surgical Drain Disk Reconstruction Scoliosis Paralysis	Parkinson's DiseaseCerebral PalsyShinglesIrritable Bowel SyndromeDiabetesStrokeConstipationBroken/Fractured BonesJoint Stiffness/SwellingSpasms/CrampsAnxietyPTSDImplants	SeizuresOpen Wound'sCrohn's Disease eNauseaBone MetsJoint ReplacementPeg TubeShuntRods/PinsDiarrheaOsteoporosisPorts/Pic LineOxygen Tank				
Medications List all medications you are herbal/nutritional supplem	currently taking including presc	ribed, over-the-counter, and				
Pain Do you have any areas of p What is the reason for you Is this new pain? Y/N Is your physician aware of t						
Activity Level In general, what is your act Bed Rest Regular exercise	ivity level? Sedentary C	Occasional exercise Competitive athlete				

Are you pregnant? Y/N	If yes, how far along are you?	
What kinds of physical act	ivities do you engage in regularly?	
Allergies		
	to latex, lotions, oils, or foods? Y/N	
Massage History		
Have you ever had a massa	age before? Y/N	
-	ou like or not like about previous experiences?	
Are there areas you would	like to focus on during this massage?	
What type of pressure wor	uld vou prefer? Light, Medium, Firm	

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

Client Signature	Date
Witness Signature	Date
Massage Therapist's Signature	Date

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.