Millinner & Joseph

The Luxury Aesthetics & Fashion Brand

MASSAGE CONSULTATION & CONSENT FORM

PERSONAL INFORMATION

Name: _____ DOB: ____/____/_____ Date of Consult: ____/____/_____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email Address: _____ Gender: ☐ M ☐ F ☐ O

How did you hear about us? ☐ Facebook ☐ Instagram ☐ Other _____

HEALTH INFORMATION

Are you currently taking any medications? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Do you suffer from chronic pain? ☐ Yes ☐ No

Have you ever had any orthopedic injuries? ☐ Yes ☐ No

How do you usually react to the sun?

Please indicate if any of the following apply to you and give details below:

☐ Cancer	☐ Headaches/migraines	☐ Arthritis
☐ Diabetes	☐ Joint replacement(s)	☐ High/Low Blood pressure
☐ Neuropathy	☐ Fibromyalgia	☐ Stroke
☐ Heart attack	☐ Kidney dysfunction	☐ Blood clots
☐ Numbness	☐ Sprains/strains	☐ Other: _____

If you have checked any of the above conditions please give details:

Any additional notes/comments regarding your health:

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LIFESTYLE INFORMATION

Please rate the following on a scale of 1 (Bad) to 5 (Excellent): ✓

	1	2	3	4	5
Quality of sleep					
Energy levels					
Stress levels					
Quality of nutrition					
Exercise habits					

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

Are there any areas (feet, face, abdomen, etc.) that you do NOT want massaged? If so, where _____ ☐ Yes ☐ No

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic / Deep tissue ☐ Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

What are your goals for this treatment session?

Please list any areas of discomfort (including which side of the body):

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Please read and check each statement to show your understanding and agreement.

	I further understand that Massage Therapy should not be construed as a substitute for medical examination diagnosis or treatment and that I should see a physician chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware
	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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
	This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
	I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she/he deems necessary.
	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.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT AND ALL THE INFORMATION DETAILED ABOVE

CLIENT	MASSAGE THERAPIST
Name: _____	Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____