Massage Therapy Waiver and Consent Form

Thank you for choosing Natural Wellness Centre for your massage therapy! It is our goal to provide you the most therapeutic experience possible. Please answer the questions below so that we can thoroughly address your needs. Rest assured that your information is confidential. Our therapists would like to hear your questions, comments, and complaints! We invite you to share them with your therapist in the way most comfortable for you; either in person, over the phone, or by e-mail! If you would like to see your therapist's license, please let us know.

Personal Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Birth Date: ___/_____/_____ Email: _____
Emergency Contact: _____
Emergency Phone: _____

Check Appropriate Items

Do you wear: □ A Hearing Aid? □ Contacts? □ Dentures? □ Pacemaker?

In which part of your body do you experience stress? □ Leg □ Neck □ Shoulders □ Back □ Head

Is your stress level: □ Light? □ Moderate? □ Heavy?

List injuries **not requiring surgery** that occurred within the past 2 years (i.e., broken bones, torn ligaments, auto accident)_____
_____
_____
_____

Please list all medications you currently take (include over-the-counter medications as well as vitamins/herbs)_____
_____
_____
_____

Are you sensitive to touch in any areas?_____

Do you have any nut /food allergies? (Which food/nuts)_____

Please look over the list of health disorders and check all that apply.

□ Bone or Joint Disease
□ Rashes
□ Broken/Fractured Bones
□ Constipation
□ Low Back/Hip/Leg Pain
□ Headaches/Head Injuries
□ Spasm/Cramps
□ Sprains/Strains
□ Varicose Veins
□ Diabetes/Type? _____
□ High/Low Blood Pressure
□ Drug/Alcohol Disorder
□ Breathing Difficulties
□ Nicotine/Caffeine Addiction
□ Fibromyalgia/Myofascial Pain Syndrome
□ Allergies
□ Bursitis
□ Warts
□ Neck/Shoulder/Arm Pain
□ Irritable Bowel Syndrome
□ Herpes/Shingles
□ TMJ/Jaw Pain
□ Depression
□ Cancer/Tumors
□ Infectious Diseases
□ Eating Disorder
□ Sinus Problems
□ Heart Conditions/Disease
□ Chronic Pain
□ Adrenal issues
□ Tendonitis
□ Athletes Foot
□ Arthritis
□ Diverticulitis
□ Fatigue
□ Sleep Disorder
□ Anxiety
□ Endometriosis
□ PMS/PMDD
□ Lymphedema
□ Bruise Easily
□ Blood Clots
□ Asthma
□ Thyroid issues (hypo/hyper)

If you checked any disorders or diseases above, please use the next few lines to explain. (Example: dates, areas of disorder/disease, type, symptoms of concern. Please be specific.)_____
_____
_____

Is there anything else about your health history that you think would be useful for your licensed practitioner to know to plan a safe and effective session for you? □ Yes □ No If yes, please explain:_____

_____

The purpose of this page is to clarify your financial responsibilities so that we focus our efforts on helping you achieve your optimal results in the shortest amount of time.

Our office requires 24-hour notice cancellation of appointments. Appointments missed or cancelled without sufficient notice will be *charged 50%* of the cost of treatment.

I consent to charge my credit card #:_____expiry date:_____for missed appointments.
Patient signature:_____

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for "full cost" of the cost of session.** Out of respect and consideration for your therapist and other customers, **please** plan accordingly and be on time.

Consent
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. 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 deems necessary._____(Initials)**

Male and female genitalia and women's breasts will not be exposed or touched at any time. Draping will be used for your privacy and comfort. Our policy requires therapists to use draping with sheets/ blankets at all times during every massage session.
Please Initial: _____

Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

Signature of Client:_____Date:____/____/_____

Signature of Licensed Massage Therapist Practitioner :_____Date:____/____/_____

We look forward to serving you!