Client Agreement

I, _____, understand that the massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

I understand and agree to abide by the therapist's polices and will not hold Normandy Farms or the therapist responsible for any personal injury or loss of property.

_____ _____

Client Signature Date

CHILD SERVICE RELEASE FORM FOR MASSAGE THERAPY

We believe everyone can benefit from receiving massages even children. What better way to teach your child the importance of caring for him/herself in a healthy and relaxing manner? They will receive the same quality service and respect with a few minor modifications to accommodate your child.
All persons under the age of 18 must have a parent or legal guardian fill out the Health Release Form below. We ask that you remain in the Wellness Center sitting area for the duration of the services. You will be asked to help escort the minor to the massage room and if needed, assist them in preparing for the massage therapy. If the child is 16 or under, the parent or legal guardian must remain in the treatment room.
Please complete the following Child Service Waiver. Make sure you have signed and dated both the Intake form and this waiver form.
By signing this form, you certify that you are the parent or legal guardian of the child receiving the massage therapy services. You acknowledge that you are aware of the health risks inherent in any form of hands on services provided from any like kind of massage services that your child will be receiving, and waive any and all claims to damages or injuries that you or your child may have against Normandy Farms and any of the registered therapists.
By signing below, you agree that you have read, understand and agree to this statement,

"I am giving up certain legal rights and or remedies."

PLEASE PRINT CLEARLY:

I _____, certify that I am a parent or legal guardian of _____, who is _____ years of age. I grant permission for my minor child to receive the selected service. I have accurately filled out the Intake Form for the minor that is going to be receiving the massage therapy services. I am aware of this legal waiver that is in full effect with this signature for the person receiving the services as well as myself.

SIGNATURE OF PARENT or LEGAL GUARDIAN _____

DATE: _____

Client Health History Form

Print clearly and complete both sides of this form. This information is critical to your massage treatment as it may affect the manner in which your therapist structures your session. All information disclosed will be kept strictly confidential.

Name: _____ Date: _____

Home Phone: (___) ____ - _____ Cell / Work Phone: (___) ____ - _____

_____

Address City State Zip Code

Occupation: _____ Male / Female Date of Birth: _____

Have you ever had a therapeutic massage before? Yes / No If yes, approximately how many? ____

What is the amount of tension in your life? 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
(none) (average) (extreme)

What physical activities do you do on a daily or weekly basis? _____

Please circle any painful or tense areas as well as regions that you hold your stress:

Head / Face	Low back	Shoulders	Neck	Abdomen
Legs / Feet	Arms / Hands	Mid-back	Other: _____	

Are you currently under a Physicians care? Yes / No For what condition? _____

Do you take medication for this condition? Yes / No

List medications you take: _____

Do you take any medications or drugs that alter sensation? (e.g., pain medication, muscle relaxants, alcohol or other depressants or stimulants) These may affect the therapist's choice of techniques.

_____

_____

Please circle any of the following health issues that you have had *in the past year*:

Allergies	Angina	Fibromyalgia	Irritable Bowel Syndrome	
Stroke	Asthma	Heart disease	Insomnia	Surgery
Blood Clots	Hepatitis	Migraines / Headaches	Varicose veins	Cancer
Herpes simplex	Phlebitis / Thrombosis	Whiplash	Carpal Tunnel Syndrome	
Hospitalization	Pregnancy	Communicable diseases	Hypertension	
Repetitive Strain Injuries	Disk problems	Immune system conditions	Sciatica	
Other:				

For therapist use: (List client preferences, supports, positioning, table height, etc.)

GENERAL MEDICAL SIGNS AND SYMPTOMS: Please indicate if you ***currently*** have any of the following conditions:

Symptom: Location: Please Describe	**Yes**	**No**	
1. Any areas of infection?			
2. Any areas of swelling, edema, or tendency to swell?			
3. Any areas of numbness or altered sensation?			
4. Any areas of pain or tenderness?			

SPECIFIC MEDICAL CONDITIONS: For your safety the therapist must be aware of ***all medical conditions.*** Therapeutic massage may affect these and your health.

Condition: Please Describe	**Yes**	**No**	
5. Arthritis:			
6. Cancer or Tumors:			
7. Cardiovascular Diseases:			Please circle all that apply: Anemia, Angina, Arteriosclerosis, Congestive Heart Failure, Heart Attack, Heart Murmur, Hemophilia, Hypertension, Varicose or Spider Veins, Other: _____
8. Diabetes:			
9. Injuries:			
10. Kidney, Liver, or Urinary problems:			
11. Respiratory Conditions:			
12. Skin Conditions:			Please circle all that apply: Acne, Abrasions / Cuts, Birthmarks / Moles, Bruises, Dermatitis, Eczema, Herpes, Hives, Poison Ivy / Oak / Sumac, Psoriasis, Skin tags, Sunburns, Warts, Other: _____
13. Surgery:			Date of Surgery: Describe:
14. Gastrointestinal Problems:			
Other Medical Conditions not mentioned above:			Please Describe:

Additional Notes:

Please read and sign:

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided by the therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I hereby give my consent to receive therapeutic massage in this setting and will not hold Normandy Farms or the therapist responsible for any personal injury or loss of property. Thank you and Please Enjoy!

_____ _____

Signature *Date*