

MassageWerx, Inc.

Survey and Consent

SURVEY		
Name:		Date:
Address:		Referred By:
		Birth Date:
Phone (home):	(work):	(cell):
Emergency Contact:		Phone #:
Occupation:		
Allergies:		
1. Goals for massage session (e.g., manage pain, relieve discomfort, maintain health, reduce stress, simply relax, etc.):		
2. Current physical discomforts (mark up Discomfort Diagram on back of this form):		
3. Current medications and corresponding condition:		
4. Have you previously received a professional massage?		Date of last massage:
5. Regular exercise (personal sports/routines, fitness classes, personal training/coaching, etc.):		
CONSENT		
<p>I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 that I am aware of. I understand that massage/bodywork practitioners 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 given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Cancellations must be made 24 hours in advance of the scheduled appointment to avoid charge. Returned checks and denied credit cards incur an additional charge of \$25.00</p>		

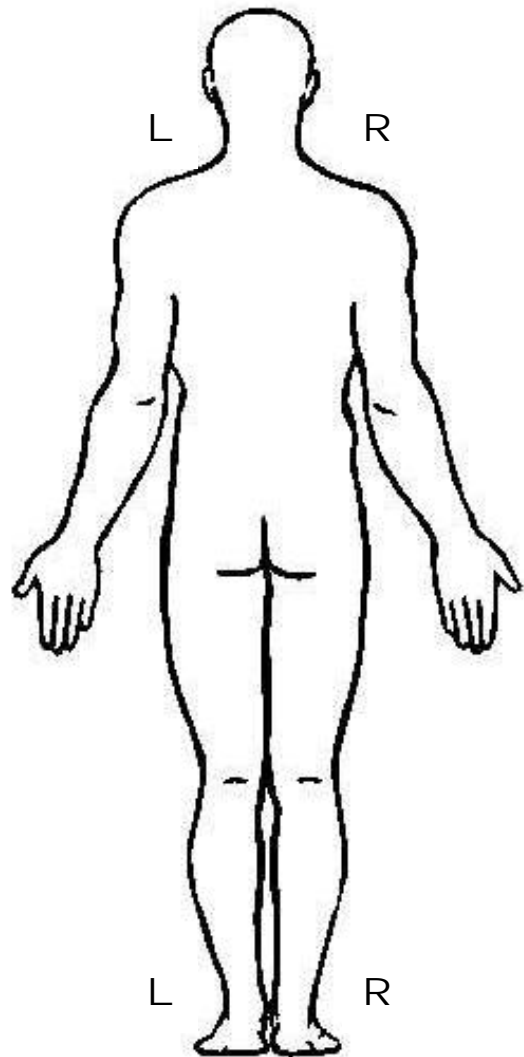
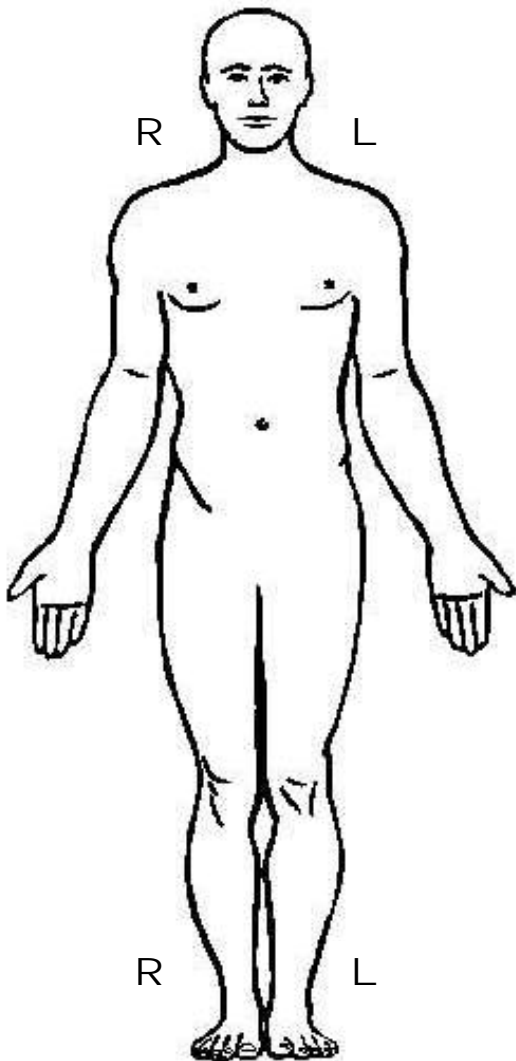
Client Signature: _____ Date: _____

(Over)

Client Discomfort Diagram

Name: _____

Date: _____



Please Identify & Describe Any Areas of Discomfort

Onset: Sudden, gradual

Duration: Hours, days, weeks, months

Frequency: Seldom, intermittent, frequent, constant

Type: Sharp, dull, achy, tingly

Severity: Mild, moderate, severe

(Over)