Alora Health Spa

Patient Information – Post-Surgery Massage Therapy

Name: _____ Date of Birth: ____/____/_____
Occupation: _____ Phone: _____
Email: _____
How did you find us? _____

Do you have permission from your doctor to receive this service? _____
What was your procedure? _____
When was your procedure? _____
Any complications during or after your procedure? If so, please specify: _____
Which medical clinic did you go to? _____

Do you take any medication? If yes, which ones? _____
_____
Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify_____

Have you had a post-surgery massage before? Yes/No Last series? _____
Results? _____

Have you had or have cancer? Yes/No If so, what type? _____

Please circle if you suffer from any of the following:
Severe Anemia/Asthma/ Allergies/ Diabetes/ Headaches/ Chronic Fatigue/ Aneurysm/ Heart Trouble/ Circulatory/ Respiratory/ High Blood Pressure/ Thrombosis

Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If yes, how many weeks? _____

Do you use any of the following and how often do you use them?
Cigarettes_____ Alcohol_____
Do you exercise? Yes/No How often? _____

In case of an emergency, whom should we call? Name: _____
Phone: _____ Relationship: _____

It is my choice to receive Post-Surgery Massage(s). I realize that the treatment is being given to assist in the healing of the body after a recent procedure. I agree to communicate with my massage practitioner anytime I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe treatments nor medications. My massage practitioner does have the right to refuse service if they feel it can cause more harm than good or need to be seen by a doctor or medical specialist. By signing on the line below I am agreeing that the questions above were answered honestly to the best of my knowledge. I also understand that my therapist is not held accountable for healing complications if any occur. If a series of sessions was purchased and I decide to cease my treatments, a refund will not be issued to me. Lastly, I agree to have an open communication with my therapist about any concerns I have before, during, and after my post-surgery massage.

Signature_____ Date: _____

OFFICE USE ONLY

Notes:_____
_____
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