



Patient Information - Massage Therapy

Name: _____ Date of Birth: ____/____/____

Occupation: _____ Phone: _____

Email: _____

How did you find us? _____

Are you currently under the doctor's care? Yes/No If so, why? _____

Do you take any medication? If yes, which ones? _____

Any other medical conditions that we should be aware of? Yes/No If so, please specify: _____

Do you have any allergies towards scented/unscented oils, lotions, or creams? Yes/No If yes, please specify _____

Cancer: What type and when? _____

Surgeries: Which one and when? _____

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? _____

Have you had a professional massage before? Yes/No If so, date of last massage ____/____/____

Any areas you would like for your therapist to concentrate on? _____

Have you ever had a Lymphatic Massage? Yes/No Last series? _____

Results? _____

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: _____

Relationship: _____ Phone: _____

It is my choice to receive Massage Therapy. I realize that the treatment is being given for the well-being of my body and mind. 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 medical treatments, pharmaceuticals, or perform spinal thrust manipulations. By signing on the line below I am agreeing that the questions above were answered honestly to the best of my knowledge. I accept Alora Health Spa's cancelation/rescheduling policy and will give at least 24 hours notice if I need to cancel or reschedule my appointments. If a series of sessions was purchased and I decide to cease my treatments, a refund will not be issued to me. I agree to have an open communication with my therapist about any concerns I have before, during, and after my massage. I undersigned, hereby acknowledge that my therapist has not, is not and will not prescribe, (order for use as medicine) for me at any time and I, the undersigned, will not hold them accountable for such.

Signature _____ Date: _____

Notes:

