



Patient Information – Post-Surgery Massage Therapy

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
How did you find us? \_\_\_\_\_

**PLEASE BE AWARE THAT WE DO NOT REMOVE DRAINS, REOPEN ANY INCISIONS OR DRAIN SEROMAS**

Do you have permission from your doctor to receive this service? \_\_\_\_\_  
What was your procedure? \_\_\_\_\_  
What areas were performed on? \_\_\_\_\_  
When was your procedure? \_\_\_\_\_  
Any complications during or after your procedure? If so, please specify: \_\_\_\_\_  
Which medical clinic did you go to? \_\_\_\_\_  
Who was your doctor? \_\_\_\_\_  
Are you currently taking 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? Yes/No When was the last session? \_\_\_\_\_  
Do you have any metal implants or wear a pacemaker? Yes/No  
Have you had or have cancer? Yes/No If so, what type? \_\_\_\_\_  
Blood pressure: Low/Normal/High  
Do you use any of the following and how often do you use them?  
Cigarettes \_\_\_\_\_ Alcohol \_\_\_\_\_  
Do you exercise? Yes/No How often? \_\_\_\_\_

Do you give permission for Alora Health Spa and staff to take photos of your procedure to monitor your progress? Yes/No \_\_\_\_\_ Initial  
Do you want your face to be included in the photos? Yes/No \_\_\_\_\_ Initial  
Do you give permission for Alora Health Spa and staff to use your photos for educational and advertising purposes? Yes/No \_\_\_\_\_ Initial

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 therapist anytime I feel like my well-being is being compromised. I understand that massage therapist do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe treatments nor medications. My massage therapist 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. 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. 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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