

Techniques Massage Healing & Wellness

Name _____ Phone _____

Address _____

Reason for visit: Check all the apply

- Pain relief
- Relieve tension / Stress
- Relieve anxiety
- Improve quality of life
- Relaxation
- Type of Surgery & Date

- Other (Explain)

Was there a specific incident that cause this pain? Check all the apply

- Car accident
- Fall
- Slept funny
- Work-related
- Sports/exercise
- Surgery
- Other (Explain)

Intensity of pain: (Circle)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Extreme

Sensation of pain: Check all the apply

- Dull
- Sharp
- Tender
- Cold
- Burning
- Other (Explain)

Have you seen other healthcare practitioners about this issue? Check all the apply

- Massage Therapist
- Physical Therapist
- Chiropractor
- Physician
- Other

Time pattern of pain: Check all the apply

- Constant (pain does not change)
- Intermittent (pain comes & goes)
- Variable (pain changes throughout the day)

Does this pain prevent you from the following activities? Check all the apply

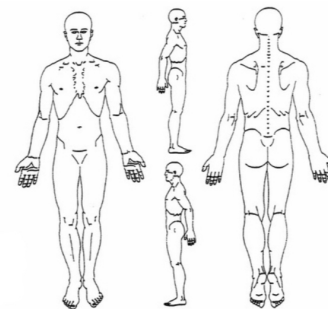
- Work
- Leisure activities
- Sports/exercise
- Sleep
- Other

When did the pain start?

Pain/discomfort is aggravated when...

Pain/discomfort improves when...

Circle areas of pain or discomfort



Massage Acknowledgment & Disclaimer

Acknowledgment of Treatment:

I, the undersigned, acknowledge that I have voluntarily sought massage therapy treatment. I understand that the purpose of this therapy is to promote relaxation, relieve muscle tension, and enhance overall well-being. I acknowledge that I have provided complete and accurate information regarding my health history and any medical conditions that may affect my treatment.

Disclaimer:

I understand that massage therapy is not a substitute for medical treatment or diagnosis. The Licensed Massage Therapist (LMT) does not claim to heal or cure any condition, and the results may vary from person to person. I acknowledge that if I experience any discomfort, pain, or adverse reactions during or after the treatment, I will inform the LMT immediately.

Unethical Behavior Policy:

I understand that any form of unethical behavior, including but not limited to inappropriate requests or advances made toward the LMT, will not be tolerated. In such cases, treatment will be immediately terminated, and no refunds will be issued. Professional boundaries must be respected at all times, and I acknowledge that I am aware of this policy.

By signing below, I confirm that I have read and understood this acknowledgment and disclaimer, and I agree to participate in the massage therapy treatment under these terms.

Full Name: (Printed) _____

Signature: _____

Date: _____