MASSAGE THERAPY INTAKE

Name _____ Date of Birth _____

Date of initial visit _____

Reason for initial visit _____

_____

_____

_____

Please list any medical conditions _____

_____

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_____

I understand that it is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm exact details of my coverage.

Date: _____

_____ _____

Patient's printed name Patient's signature

_____ _____

Guardian/Legal Representative printed name Guardian/Legal Representative signature

_____

Relationship/Representative's Authority