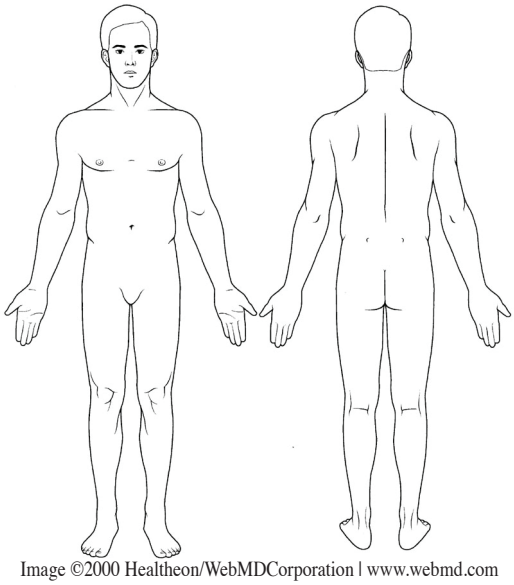
On the chart below, use an "X" to mark bruises, cuts, painful or ticklish areas to avoid during your massage.
Circle areas of tension, and those needing extra work.



BY SIGNING BELOW I CONFIRM THAT I UNDERSTAND AND AGREE WITH THE FOLLOWING:

If I become uncomfortable or experience any pain during the massage, I may ask the massage therapist to adjust the pressure and/or strokes to my comfort or to stop the massage, and she will then end the session.

The massage I will receive is a blend of Swedish, Deep Tissue, Trigger Point, Reflexology, Joint Range of Motion Techniques and Stretching applied to soft tissues of the back, buttocks, thighs, calves, feet, shoulders, arms, hands, head, scalp, face, ears, neck, and chest/pectorals—except any areas to avoid as noted above.

Indications (reasons) for massage are stress, pain in the muscles, muscle soreness, muscular spasms; and pain in the joints, pain in the hands or feet; and tension headaches and migraines.

Contraindications to receiving massage are abnormal body temperature, acute infectious disease, inflammation, osteoporosis, varicose veins, blood clots, swelling, high or low blood pressure, cancer, intoxication, skin problems, hernia and other conditions as listed above.

The massage therapy I will receive is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation. It is not a substitute for medical treatment. The massage therapist does not diagnose illness, disease or any other physical or mental disorders, and does not prescribe treatment.

My privacy and body will be respected at all times. Proper draping will be observed at all times for my comfort, security and warmth (draping is the use of a sheet to cover all but the body area being massaged.)

There will be no breast massage of a female client without her written consent.

There will be NO massage performed on any private areas of my body.

The information I have provided on this form concerning my state of health and my medical history is accurate and complete. I freely give my permission to be massaged. By signing this form, I also give consent for future sessions. If I miss a scheduled appointment without giving 24 hour notice I agree to pay full missed appointment(s) fee. Do you have any other medical conditions that I should be aware of before receiving your massage?
If YES, please specify _____

_____

Client Signature Date Massage Therapist Date

The Retreat Massage & Day Spa

TINY TOUCH THERAPY

Colleen Dolan, LMT MT101392

CONFIDENTIAL THERAPEUTIC MASSAGE THERAPY CLIENT HEALTH INTAKE FORM

NAME_____**BIRTHDAY**____/____/_____**DATE**___/____/_____

ADDRESS_____**CITY/STATE/ZIP**_____

HOME PHONE( )_____**WORK( )**_____**CELL( )**_____

OCCUPATION/EMPLOYER_____**E-MAIL**_____

REFERRED BY_____**REASON FOR APPOINTMENT**_____

Have you had a professional massage before? Y/N When_____ **By whom**_____

What did you like/dislike about your previous massage session? _____

Are you currently under the care of a physician and/or a chiropractor for any reason? Y/N

If yes, please explain_____

Are you currently on any prescribed or OTC medications? Y/N

List_____

Place a checkmark beside the conditions you are currently experiencing:

Pregnancy/Nursing	_____	High or Low Blood Pressure	_____
Osteoporosis	_____	Fibromyalgia	_____
Skin Allergies	_____	Multiple Sclerosis	_____
Tendonitis or Bursitis	_____	Cancer/Tumor(s)(past or present)	_____
Carpal Tunnel	_____	Allergies/Sinus/Respiratory Condition	_____
Scoliosis/H-Rod	_____	Seizures/Convulsions/Epileptic Disorder	_____
Phlebitis/Blood Clots	_____	Migraines/ Headaches/Whiplash	_____
Diabetes	_____	Contagious or Infectious Condition	_____
HIV/Aids Positive	_____	Heart Disease or Circulatory Problems	_____
Varicose/Spider Veins	_____	Herniated/Ruptured/Bulging Disc	_____
Swelling/Bruise Easily	_____	Facial Reconstruction/Injections/Implants	_____
Spinal Problems	_____	Dentures/Contact Lenses/Hearing Aids	_____
Chronic Pain/Fatigue	_____	Elevated Cholesterol	_____
Stress/Tension/Anxiety	_____	Low Back Pain/Sciatica	_____
Pinched Nerve/Numbness	_____	Arthritis/Rheumatoid/Osteoarthritis	_____

Any other medically supervised condition(s)? _____

List previous Surgeries, Implants, and/or including Pacemaker_____

Suffered Accident, MVA, or Injury within the last 2 years?_____