Wellness Form

ABOUT YOU

Name: _____ Today's Date: _____/_____/_____

Address:_____ PH:_____

City: _____ State: _____ Zip: _____ Birthdate: _____/_____/_____

Email: How did you hear about Viride massage?

Emergency Contact: _____ PH: _____ Relation: _____

HEALTHHISTORY

Have you had professional massage before? ·Yes ·No

Are you Pregnant? · Yes · No

Do you have any allergies? · Yes · No

Do you have sensitivity to heat? · Yes · No

Do you have any particular goals in mind for this massage session? · Yes · No

Please explain: _____

Are you currently taking any medications? · Yes · No

If yes, please list:_____

Please check all that apply

A doctor's authorization to receive massage may be required for certain health conditions.

( ) High or Low blood pressure
( ) Diabetes
( ) Headaches/Migraines
( ) Cancer
( ) Neuropathy (decreased sensation)
( ) Herniated/Bulging disc
( ) Fibromyalgia
( ) Epilepsy
( ) Surgery
( ) Sprains/Strains
( ) Blood Clots
( ) Heart condition
( ) Varicose veins
( ) Skin conditions
( ) Recent injections, fillers or implants
( ) Easy bruising
( ) Artificial joint
( ) Swollen glands
( ) Arthritis
( ) Tendonitis
( ) Osteoporosis/Osteoarthritis
( ) Recent accident or injury

Please explain any condition that you have marked above:

Consent is needed to massage these areas : ·Face ·Scalp ·Abdomen ·Gluteals ·Pectorals

x

AUTHORIZATION

By signing below, I agree that I have read and understand:

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. It is my responsibility to immediately inform the therapist If I experience any pain or discomfort during this session. I understand that massage therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I further understand that massage should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any ailment that I am aware of. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature: X_____ **Date:**_____