



Do you have any allergies (nuts or others)? If yes, please specify \_\_\_\_\_

Are you sensitive to any oils, lotions or fragrances? If yes, please specify \_\_\_\_\_

Are you taking any medications? (Include non-prescriptive drugs/supplements)

Prescription skin creams  Transdermal patches  Aspirin  Tylenol  Motrin/Ibuprofen  Diuretics

Antibiotics  Herbs  Vitamins  Heart medicine  Allergy medicine  Pain medicine

List any medications here \_\_\_\_\_

Please check if you currently have or have had in the past any of the items below:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck/back injuries      | <input type="checkbox"/> Heart/circulation problems | <input type="checkbox"/> Fibromyalgia                      |
| <input type="checkbox"/> Headaches, migraines    | <input type="checkbox"/> High/low blood pressure    | <input type="checkbox"/> Numbness/Shooting Pains           |
| <input type="checkbox"/> Seasonal allergies      | <input type="checkbox"/> Major accident             | <input type="checkbox"/> Sprains                           |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> Recent injuries                   |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Blood clots                | <input type="checkbox"/> Fusions, pins or screws           |
| <input type="checkbox"/> TMJ/jaw problems        | <input type="checkbox"/> Implants                   | <input type="checkbox"/> Contacts lenses                   |
| <input type="checkbox"/> Abnormal skin condition | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Pregnant. if yes, due date: _____ |

Please explain any conditions that you have marked above \_\_\_\_\_

Have you had any major life changes recently? \_\_\_\_\_

I understand that massage therapy is provided for the basic purpose of relaxation and relief of muscle tension. Massage therapy is not a substitute for medical diagnosis and/or treatment. If I experience any pain or discomfort during the session, I will alert the practitioner so modifications can be made. Because massage therapy is contraindicated under certain medical conditions, I agree to fully disclose all of my known medical conditions and medications. I agree to keep my medical profile updated and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will still be responsible for full payment of the session.

*My signature also indicates my consent to the following: Failure to cancel appointments at least 24 hours in advance or failure to show up for my appointment will result in a charge of 50% of the scheduled appointment fee which will be processed on the credit card retained on file to reserve appointments. If a credit card is not available to charge I understand that a bill will be sent to my home and agree to pay such bill.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

*(If under 18, signature of parent or guardian)*

**Parental Consent for Clients Under 18:** By signing above I hereby authorize the massage therapists at Living Light Massage to provide massage therapy services to my child or dependent. I also approve of any future sessions until further notice.

**THANK YOU - ENJOY YOUR SESSION**

EC  DBE  TY Date \_\_\_\_/\_\_\_\_/\_\_\_\_