DOHR • COLL • GADSON
OB/GYN ASSOCIATES & MEDICAL SPA

MASSAGE CLIENT INFORMATION & CONSENT

Medical information: Have you ever been diagnosed with any of the following conditions:

Allergies	Yes	No	Hemophilia	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Swelling of Joints	Yes	No	High Cholesterol	Yes	No
Back Pain	Yes	No	Lupus	Yes	No
Bursitis	Yes	No	Multiple Sclerosis	Yes	No
Blood Disorder	Yes	No	Nerve Damage	Yes	No
Bruise Easily	Yes	No	Osteoporosis	Yes	No
Cardiac Problems	Yes	No	Pacemaker	Yes	No
Circulatory Problems	Yes	No	Seizures/Epilepsy	Yes	No
Cancer	Yes	No	Spinal Condition	Yes	No
Carpal Tunnel Syndrome	Yes	No	Stroke	Yes	No
Cerebral Palsy	Yes	No	Tendonitis	Yes	No
Cystic Fibrosis	Yes	No	TMJ Syndrome	Yes	No
Diabetes	Yes	No	Varicose Veins	Yes	No
Fibromyalgia	Yes	No	Other _____		
Headaches/Migraines	Yes	No	_____		
Heart Disease	Yes	No	_____		

Overall Stress Level: Low Medium High

List any medications you are currently taking: _____

_____

_____

Are you pregnant? Yes No

Do you have tension or soreness in a specific area? _____

List any recent injuries, accidents or surgeries:

_____

What kind of massage pressure do you prefer? _____

I will keep the practitioner updated to any changes in my medical profile and understand that there is not medical liability if I should fail to do so. I have stated all my known medical conditions.

Client Name: _____Date: _____

Client Signature: _____

Practitioner Signature: _____