THERAPEUTIC MASSAGE BY TANYA
Tanya Sissoyev, LMT

Name_____Phone(____)_____DOB_____

Address_____City_____State_____Zip_____

E-Mail:_____ Referred by:_____ Phon(____)_____

Occupation_____ Male / Female Physician_____

In case of an emergency:_____Phone(_____)_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage session? Yes No How recently?_____

What are your massage goals?_____

What kind of pressure do you prefer? light medium firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes	No	Do you frequently suffer from stress?	Yes	No	Do you bruise easily?
Yes	No	Do you have diabetes?	Yes	No	Any broken bones in past 2 yrs?
Yes	No	Do you experience frequent headaches?	Yes	No	Any injuries in past 2 yrs?
Yes	No	Are you pregnant? Which trimester?_____	Yes	No	Do you have tension or soreness anywhere?
Yes	No	Do you suffer from arthritis?	Yes	No	Do you have cardiac/circulatory problems?
Yes	No	Are you wearing contact lenses?	Yes	No	Do you suffer from back pain?
Yes	No	Are you wearing dentures?	Yes	No	Do you have numbness or stabbing pains?
Yes	No	Do you have high blood pressure?	Yes	No	Are you sensitive to touch/pressure in any area
Yes	No	Are you taking high blood pressure meds?	Yes	No	Have you ever had surgery? Explain below:
Yes	No	Do you suffer from epilepsy or seizures?	Yes	No	Other medical conditions or medications? List:
Yes	No	Do you suffer from any joint swelling?	Yes	No	Do you have any skin problems or allergies?
Yes	No	Do you have varicose veins or blood clots?	Yes	No	Do you have any contagious diseases?
Yes	No	Do you have osteoporosis?	Comments_____		

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, 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. 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 practitioner updated as to any changes in my medical profile 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 be liable for payment of the scheduled appointment.

The undersigned acknowledges that the service provider is an independent contractor. Ancient Paths Midwifery and Family Birth Center is not liable for claims arising from any services, sales and gift certificates provided by Tanya Sissoyev, LMT.

Client Signature_____Date_____

Practitioner Signature_____Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize_____to administer massage therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian_____Date_____