



Reflections Massage Therapy LLC by Elly Krumrei Licensed Massage Therapist

Name _____ Phone () _____ DOB _____

Email: _____

Occupation _____

In case of 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/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Yes No Do you have diabetes?
Yes No Do you experience frequent headaches?
Yes No Are you pregnant?
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses?
Yes No Are you wearing dentures?
Yes No Do you have high blood pressure?
Yes No Are you taking high blood pressure medication?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies?

Yes No Do you bruise easily?
Yes No Any broken bones in the past two years?
Yes No Any injuries in the past two years?
Yes No Do you have tension or soreness in a specific area?
Please specify _____
Yes No Do you have cardiac or circulatory problems?
Yes No Do you have numbness or stabbing pains?
Yes No Are you sensitive to touch or pressure in any area?
Yes No Have you ever had surgery? Explain below.
Yes No Other medical condition, or are you taking any medications I should know about?

Comments _____

I understand that the massage/bodywork 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 or bodywork 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/bodywork 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/ bodywork 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.

I have read and understand Reflections Massage Therapy LLC by Elly Krumrei Licensed Massage Therapist office policies

Client Signature _____ Date _____
Practitioner Signature _____ **Date** _____

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

Signature of Parent or Guardian _____ Date _____