Dr. R. van Aardt
Cosmetic Medicine

# MASSAGE THERAPY CONSENT

Name: _____ Date of Birth: _____
Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____
Email: _____ Consent to use: __Y __N
Address: _____
Occupation:_____ Primary Physician: _____
Emergency contact: _____ Relationship: _____ Tel #:_____-_____-_____
How did you here about us?

**Medical Information:**

List Medications: _____

_____

Please indicate any of the following that apply to you:

__ Cancer
__ Headaches / Migraines
__ Arthritis
__ Kidney Dysfunction
__ Joint Replacement(s)
__ High/Low Blood Pressure
__ Sprains or Strains
__ Fibromyalgia
__ Stroke
__ Heart Attack
__ Diabetes
__ Blood Clots
__ Numbness
__ Neuropathy

Are you currently pregnant? __Y __N
If YES, how far along: _____
If YES, any risk factors: _____

Do you suffer from Chronic Pain? __Y __N
If YES, explain: _____
What makes it better: _____
_____
What makes it worse: _____
_____

Have you had any orthopaedic injuries? __Y__N
If YES, List: _____
_____

**Direct Billing Information:**

Insurance Provider: _____
Policy Holder Name: _____
Policy Holder Birth Date: _____
Policy Number:_____
Member ID #: _____

_____ _____
Print Name of Therapist RMT #

_____ _____
Signature of Therapist Date

**Massage Information:**

Have you had a professional massage before? __Y __N

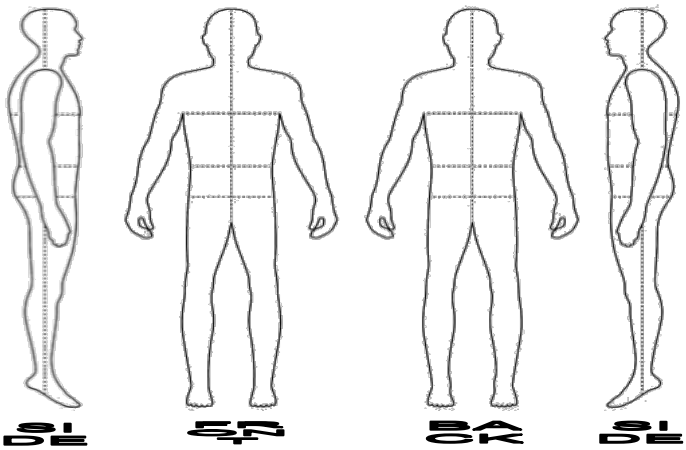
What type of massage are you seeking?
__ Relaxation __ Therapeutic / Deep Tissue
Other: _____

What pressure do you prefer?
__ Light __ Medium __ Deep

Do you have any allergies or sensitivities? __Y __N
If YES, what: _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? __Y __N
If YES, explain: _____

**Circle any areas of discomfort:**




**My signature below signifies that I have completed this form to the best of my ability and knowledge and I agree to inform my therapist if any of the above info changes at any time.**

_____
Print Name of Client

_____ _____
Signature of Client Date