Ashiatsu by Carol/Aloha Services

E-mail: _____

Name: _____ Date: _____

Address: _____

Phone: _____ _____ Birth date (M/D/Y): _____
Home Work or Cell

Occupation: _____ Exercise: _____

Purpose for getting massage: _____

Areas you would like extra attention: _____

Emergency Contact: _____ Phone: _____

Yes No Ever received a professional massage? If yes, when was your last massage? _____

Have you been diagnosed or are you currently under treatment for the following medical conditions?

Yes	No	High Blood Pressure	Yes	No	Allergies _____
Yes	No	Cardiovascular Disease, Pacemaker	Yes	No	Numbness or stabbing pains anywhere
Yes	No	Diabetes (type) _____	Yes	No	Easy bruising
Yes	No	Varicose Veins	Yes	No	Arthritis _____
Yes	No	Cancer	Yes	No	Currently Under Medical Care/Supervision
Yes	No	Epilepsy or seizures	Yes	No	Back Pain
Yes	No	Contagious Disease	Yes	No	Surgery _____
Yes	No	Osteoporosis	Yes	No	Scoliosis
Yes	No	Skin rash, open sore, abscess, boil	Yes	No	Spondylolisthesis
Yes	No	Phlebitis	Yes	No	Recent Eye Surgery
Yes	No	Edema due to kidney or liver problems	Yes	No	Herniated Disk _____
Yes	No	Medications (please list below)	Yes	No	Currently Pregnant _____
Yes	No	Skin sensitive to lotions, oils etc.	Yes	No	Breast implants within 9 months
Yes	No	Frequent or Severe Headaches	Yes	No	Spondylitus (stage) _____
Yes	No	Recent Fractures _____	Yes	No	Hiatal Hernia

_____

_____

_____

_____

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Please take a moment to carefully read the following information and sign where indicated. If you have certain medical conditions or symptoms, massage/bodywork may be contraindicated. A **release from your physician may be required** prior to receiving massage.

I understand that the massage/bodywork received here is for the **purpose of relaxation**, stress reduction, relief from muscular tension and/or enhancing circulation and energy flow.

I understand that the massage/bodywork received here is **not a substitute for medical treatment** and that the massage therapist does not diagnose, treat or prescribe treatment for any physical or mental disorder or provide spinal or skeletal adjustments. The massage therapist is not offering medical treatment.

Because massage should not be performed under certain medical conditions, I affirm that I have **stated all my known medical conditions** honestly. I take responsibility to inform the massage therapist of any changes in my physical condition on an ongoing basis, and agree that there will be no liability on the part of the massage therapist should I fail to do so.

I agree 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 full payment for the session.

I understand that **light bruising is not uncommon** after massage and is not cause for alarm. I agree to inform the massage therapist immediately if the massage is painful or too much pressure is used.

Session will include Swedish/Deep Tissue/Acupressure / Hot Stone / Ashiatsu® / Sacred Lomi techniques.

Ashiatsu only: I understand that Ashiatsu is a deep tissue technique ideally suited for clients with thick muscles and enough body weight. The massage therapist is certified in Ashiatsu, and may not offer it to all physiques. I will not hold the massage therapist liable for any pain, stiffness, soreness, skin irritation or redness, marks, bruises, headaches, sinus congestion or any injury or condition that may result from my treatment.

Areas of the body to be massaged: _____

Areas to be avoided (if any): _____

Draping will always be used unless otherwise agreed in writing by both parties and for therapeutic purposes. For female clients, LMT **will not engage in breast massage without written consent.**

I request massage therapy without draping: _____

I agree to perform massage therapy without draping: _____

I agree that for any reason **I may ask the massage therapist to stop the massage and the session will end**. In respect for the time that was reserved for me, I agree I will still make full payment for the session.

Cancellation Policy:

I agree to provide at least 24 hours advance notice if I am unable to honor an appointment or pay $50. I will pay the full value of the service scheduled if I don't show up. **I understand that any fee must be paid to reschedule** and that not showing up for appointments may result in refusal to schedule further sessions.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

You may register any complaints about my service with **Texas Department of Licensing and Regulation**: P.O. Box 12157, Austin, Texas 78711, (512) 463-6599, Toll-Free (in Texas): (800) 803-9202