



**MESSAGE CLIENT INFORMATION AND INFORMED CONSENT**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Mobile/Cell \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Please state any recent or past injuries or medical treatments \_\_\_\_\_

Please state what you hope to get from your massage session: Stress Relief \_\_\_\_\_

Relieve Neck & Shoulder Pain/Tension \_\_\_\_\_ Low Back \_\_\_\_\_

Other \_\_\_\_\_

Do you have any of the following conditions? Please circle.

Life Changes or Personal Loss Due To:    Death    Divorce    Job Loss/Change    Move  
 Other \_\_\_\_\_

Headaches	Grief Process	High Blood Pressure
Skin Disorder	Phlebitis	Varicose Veins
Pregnancy	Heart Ailment	Allergies
Cancer	Diabetes	Fever
Elevated Cholesterol	Infectious Conditions	Chronic Pain
Other _____		

Are you currently under the care of a health professional? \_\_\_\_\_

Who should we contact in emergency \_\_\_\_\_ Phone \_\_\_\_\_

**I give my permission to receive the treatment offered at this establishment. I understand there is no implication of medical treatment of any kind offered to me. No promise of healing is given.**

I, \_\_\_\_\_ (client) understand that

massage therapy provided by, Open Circle Wellness, Chad or Shannon Abbott (Therapists) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purpose for massage therapy are specified below:

---

---

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I understand the therapist's policies and agree to abide by them.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**PLEASE TURN CELL PHONES OFF DURING YOUR SESSION!!**  
**PLEASE GIVE 24 HOUR NOTICE IF YOU CANNOT KEEP YOUR APPOINTMENT**