

## Chair Massage Consent Form

Thank you for booking your chair massage! We strive to make your experience pleasurable, therapeutic, and a small treat to keep you energized and refreshed throughout your day.

PLEASE COMPLETE THIS FORM BEFORE YOUR FIRST APPOINTMENT

Name \_\_\_\_\_ Email \_\_\_\_\_  
(Please print.) (We will send you a discount coupon.)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Have you had or do you presently have any of the following conditions?

Please circle all that apply:

Blood clots    Cancer    Diabetes    Dizziness/Vertigo    Heart problems

High Blood Pressure    High Cholesterol    Joint Replacement    Chronic Headaches

Pregnancy (No massage for pregnancy in the 1<sup>st</sup> trimester.)    Spinal Fusion    Whip Lash

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you under a Doctor's care for any recent surgery, injury or ailment that could be affected by today's massage?    **Yes**    **No**

If yes, please describe.

\_\_\_\_\_

\*I take responsibility to alert my therapist to any physical changes that occur in my health in the future.

\*Therapeutic Connections is not responsible for the aggravation of any condition that was present but not disclosed to the therapist at the time of the massage.

Signature \_\_\_\_\_ Date \_\_\_\_\_