Disclaimer Form

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Date: ☐☐ / ☐☐ / ☐☐ Referred by:_____

Name: _____ Occupation: _____

Address: _____

Email: _____

Mobile: ☐☐☐☐ ☐☐☐ ☐☐☐ Work: ☐☐☐☐☐☐☐☐☐☐

Home: ☐☐☐☐☐☐☐☐☐☐

DOB: ☐☐ / ☐☐ / ☐☐

History of Injuries, illnesses and/or surgeries:

_____

_____

_____

Regular physical activities/sports:

_____

_____

Circle any of the following that you have or have had within the past year:

PAIN:	Headaches	Back	Chest	Abdomen	Hip	Leg
	Shoulder	Neck	Arm	Pelvis	Groin	Buttock
DISORDERS:	Digestion	Cramps	Seizures	Asthma	Fibromyalgia/CFS	
	Scoliosis	Depression	Anxiety			

Other:

_____

_____

Present Medications & Supplements:

_____

_____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the proper health care providers of my condition. I understand that the massage therapist does not diagnose illness or disease, and does not prescribe medications.
If for any reason cancellation is necessary, I will give 24 hours notice. I understand that if I do not give this notice, I will be charged for the missed appointment in full, or less than 24 hours notice, I will be charged half the price of the booked session unless it can be filled.

Signature: **Date:**