Massage Therapy Agreement and Release of Liability

Name: _____ Address: _____

Cell Phone: _____ City:_____

Email: _____State: _____Zip_____

Birthday for discount: _____

Welcome to A Touch Above Women's Holistic Wellness. We're delighted you have chosen our massage therapy & holistic services. **Due to table weight restrictions & liability, we are unable to see any clients who weigh over 275 pounds.**

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do feel discomfort, please ask your therapist to adjust the level of pressure. You understand and voluntarily accept any risk of which you have been advised associated with your massage, or from any use of this facility, and hereby release A Touch Above (including its employees, practitioners, agents, and insurers) from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting there from. You release all liability if you are over 275 pounds and the table breaks. You further hereby release all of the foregoing personnel and entities from all liabilities arising from any such injury or damage resulting from your failure to disclose any pre-existing condition, limitation, or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session due to health-related concerns. In this event you may be required to provide A Touch Above with a physician's medical release prior to continuing treatment.

The undersigned acknowledges that she had read this agreement.

Signature: _____ Date: _____

Name:_____Referred by:_____
Date:_____ Birthday_____Email:_____Phone:_____

CURRENT HEALTH CONDITIONS

Have you received massage therapy before? ___Yes ___No If yes, when was your last session?_____

Your primary reason for this appointment (check all that apply)

Stress Reduction ___Relaxation____Injury____Date of Injury_____Abdominal Massage_____

Long Term Pain____ Muscle Spasms/Tension____Lymphatic_____ Teraherz session_____

Please describe Specific areas of pain/discomfort _____

_____

When did you first notice the problem?_____

What caused it?_____ What aggravates it?_____

Is condition getting worse? Yes___No___Constant____Comes & Goes_____

Does this condition interfere with: Work____ Sleep____ What else_____

Line of work: current & past? _____ Do you see a Chiropractor?_____ If so, Who& How often?_____ Have you tried Acupuncture before?_____If so, Who?_____

How much water do you drink?_____Caffein & Type?_____

How do you sleep at night? Back Side Stomach

Do you sleep with a pillow between legs & arms? _____

Please check all that apply now or in past:

____Back Problems	____Headaches	____Arrthritis
____Cancer	____Heart Problems	____Low Energy
____Carpal Tunnel	____Insomnia	____Mental Fog
____Diabetes	____Muscle spasms/cramps	____Pregnant
____Disc Problems	____Neck Problems	____Recent surgeries -
____Fibromyalgia	____Stroke	____Spinal Injuries
____Allegies	____Auto-Immune	____High Blood Pressure

<u>On a scale from 1 -10.</u>

1. How committed are you to improve your overall health? _____What holds you back?_____
2. Stress level on average ?_____

3. Anxiety level on average? _____
4. How important is prevention to you? _____

How often do you have bowel movements? _____
How often do you exercise?_____ Types:_____
On Average how much sleep do you get each night?_____
How often do you eat dairy products & type?_____
How often do you eat corn products & type?_____
Have you gotten the Covid vaccine? _____ # of boosters?_____
Do you have any digestions concerns?_____Explain:_____
Do you have any weight concerns?_____ Explain:_____ Do you have fertility challenges?_____
Do you take Collagen?_____If so, Liquid, Pills or Powder?_____
Do you take Probiotics?_____Pre or Post biotics?_____If so, what brand and how often?_____
Do you have problems sleeping at night? _____Explain:_____
Do you have low energy?_____What do you do about it?_____
Do you get sick often?_____

Do you wear contacts?_____Have you had eye lenses surgery?_____
Are you wear hearing aids?_____
Are you on your period now?_____ Do you have bad cramps usually?_____ Do you have a pacemaker?_____
Do you have high blood pressure? _____
Allergies:_____

List current medications-_____
_____
List of current Supplements-_____
_____
_____
Typical Diet:_____
_____
Cravings:_____

Tara Safran- Holistic Healer 970-749-4840
10602 N 97th E Ave, Owasso, OK 74055