Replenishing Touch Massage, LLC
134 E State St (Edgmont St entrance)
Media, PA 19063 484.441.1456
www.ReplenishingTouch.com

Client Information & Consent

Name _____ Referred by _____

Birthdate _____ E-Mail _____ Reason for visit _____

Address _____ Phone #s: (home)_____

City _____ State _____ Zip _____ (mobile)_____

Occupation_____ Employer_____ (work)_____

Doctor's Name _____ Emergency Contact Name/Phone _____

Please carefully read and answer the following, and sign in the presence of your massage practitioner.

Yes No Have you previously experienced a professional massage/bodywork session? If so how recently?_____

If you answer yes to any of the following, please write a clear explanation if more detail is appropriate.

Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you experience frequent headaches?
Yes No Are you pregnant?
Yes No Do you suffer from arthritis?
Yes No Do you wear contact lenses?
Yes No Do you wear dentures or a partial?
Yes No Do you have high blood pressure?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have any contagious disease?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies?
Yes No Do you bruise easily?

Yes No In the past 2 years: a)have you had any broken bones?
Yes No b) been in an accident or suffered any injuries?
Yes No Do you have tension/soreness in any specific areas?
Yes No Do you have cardiac or circulatory problems?
Yes No Do you suffer from back pain? upper/mid/lower?
Yes No Do you have any numbness or stabbing pain anywhere?
Yes No Are you very sensitive to touch or pressure in any area?
Yes No Have you ever had surgery? Please elaborate if so.

Please list any other medical conditions along with any medications:

_____

_____

_____

_____

Additional comments/concerns: _____

_____

_____

_____

I understand that massage and bodywork treatments administered by owners/staff/contractors of Replenishing Touch Massage, LLC are of a non-sexual nature, for the general purpose of stress reduction, relieving muscular tension/spasm, or for increasing circulation and energy flow. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and that I will be liable for payment of the session in full as it was scheduled. I agree to immediately inform the practitioner if I experience any pain or discomfort during the session so that the pressure and/or movements may be adjusted to my level of comfort. I further understand that the massage practitioner does not diagnose illness, disease, or any other physical, mental, or emotional disorder. As such, the massage practitioner does not prescribe medical treatment or medication, nor perform spinal manipulations. I understand that massage/bodywork is not a substitute for medical examination and/or diagnosis and that I should see a qualified medical specialist for any physical ailment I might have. Because the massage practitioner must be aware of all existing conditions to determine if massage is beneficial for me, I attest that I have stated all my known medical conditions in writing above, and take it upon myself to keep the massage practitioner updated on all aspects of my health for subsequent visits, understanding that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature (in person before session) _____ Date _____

Practitioner Signature _____ Date:_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage/bodywork techniques to my child or dependent as deemed appropriate by the practitioner.

Signature of Parent/Guardian _____ Date: _____

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http://www.ReplenishingTouch.com/aware-cupping.html

Client Information & Consent for Cupping Therapy/Baguanfa

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or concerns with draping (so my body is kept comfortably covered) during the session.
- Information has been provided to me about Baguanfa Cupping Techniques. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Baguanfa. I have fully disclosed all health factors to my therapist, to avoid any complications.
- It has been explained to me that there is the possibility of discolorations visible on the skin that can occur from the release and clearing of stagnation and toxins from my body.
- I also understand that this reaction is not bruising, but due to the pathogenic factors being drawn to the surface to be cleared away by my circulatory systems.
- I further understand that such discolorations will dissipate in a period of time from a few hours to as long as 2 weeks in some cases. My after-care activities can impact their dissipation.
- I understand that Baguanfa modalities should not be combined with aggressive exfoliation.
- I understand that I should avoid exposure to cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and that I should avoid such conditions.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean drinking water.

I [print name] _____ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and understand that there shall be no liability on the practitioner's part should I fail to do so.

Date_____ Signature of Client _____

Date_____ Signature of Practitioner _____