



Patient Information – Post-Surgery Massage Therapy

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

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

Email: \_\_\_\_\_

How did you find us? \_\_\_\_\_

Do you have permission from your doctor to receive this service? \_\_\_\_\_

What was your procedure and when? \_\_\_\_\_

Where there any complications during or after your procedure? \_\_\_\_\_

Which medical clinic did you go to? \_\_\_\_\_

Do you take any medication? If yes, which ones? \_\_\_\_\_

Do you have any allergies towards scented/unscented oils, lotions or creams? Yes/No If yes, please specify \_\_\_\_\_

Have you had a post-surgery massage before? Yes/No Last series? \_\_\_\_\_

Results? \_\_\_\_\_

Have you had or have cancer? Yes/No If so, what type? \_\_\_\_\_

Please circle if you suffer from any of the following:

Severe Anemia/Asthma/ Allergies/ Diabetes/ Headaches/ Chronic Fatigue/ Aneurysm/ Heart Trouble/ Circulatory/ Respiratory/ High Blood Pressure/ Thrombosis

Pulse rate: \_\_\_\_\_ Blood pressure: Low/Normal/High Cholesterol: Low/Normal/High

If female, are you pregnant? Yes/No If yes, how many weeks? \_\_\_\_\_

Do you use any of the following and how often do you use them?

Cigarettes \_\_\_\_\_ Alcohol \_\_\_\_\_

Do you exercise? Yes/No How often? \_\_\_\_\_

In case of an emergency, whom should we call? Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_

It is my choice to receive Post-Surgery Massage(s). I realize that the treatment is being given to assist in the healing of the body after a recent procedure. I agree to communicate with my practitioner anytime I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe treatments nor medications. My therapist does have the right to refuse service if they feel it can cause more harm than good or need to be seen by a doctor or medical specialist. By signing on the line below I am agreeing that the questions above were answered honestly to the best of my knowledge. I also understand that my therapist is not held accountable for healing complications if any occur. If a series of sessions was purchased and I decide to cease my treatments, a refund will not be issued to me. Lastly, I agree to have an open communication with my therapist about any concerns I have before, during, and after my post-surgery massage.

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

Notes:

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