

Massage Agreement

By signing this Agreement, I am agreeing to the following terms of Vie:

- Full payment for all sessions must be made prior to scheduling my first appointment.
- **I will be charged for a cancelled appointment unless I notify Vie of cancellation at least 24 hours prior to the scheduled time.** If I am more than 15 minutes late for my appointment, I agree that the lost time will be forfeited, but I will be charged for that session.
- I understand that Vie will try to accommodate preferences for certain appointment times and specific massage therapist requests, but cannot guarantee availability due to other appointments, scheduling conflicts, and other factors.
- I understand that a massage therapist does not diagnose illness or disease, prescribe medicine, nor perform spinal manipulations. I further understand that massage therapy is for the purpose of reducing stress, muscular spasm or pain, and for improving circulation, energy and sense of well-being.

1. Have you ever had a professional massage? Yes No

2. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Please list previous injuries or surgeries and their dates:

Please indicate any present symptoms or current complaints:

<input type="checkbox"/> Acute Injury or Infection	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Spasms
<input type="checkbox"/> Allergies/Sensitivities*	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nervous Tension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Numbness or Tingling
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Phlebitis/Thrombosis
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Stiff Neck/Shoulders
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> TMJ Dysfunction
<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Range of Motion Loss	<input type="checkbox"/> Wear Contacts

- In signing below, I agree to the above conditions as well as other policies of the facility.

Signature

Printed Name

Address

(H) Phone Number

City, State, Zip

(W) Phone Number

Email Address

Birthdate

Staff/Trainer

Date