anna scire
massage therapist

Name: _____ Phone: _____

Email: _____ D.O.B: _____

Address: _____City: _____State: _____ Zip:_____

Occupation: _____ Referring Physician: _____

Primary Complain:

_____

_____

Existing medical conditions:

_____

Were you ever diagnosed with cancer? If yes, what treatments have you undergone?

_____

Current medication:

_____

Previous injuries, surgeries and when:

_____

I understand that there is a 24 hour cancellation policy and if I arrive late the original end time will be the same.

I understand that Massage Therapists do not perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I neglect to do so. I agree to hold harmless, release, and indemnify this licensed and certified Massage Therapist against any liability arising from the application of massage therapy.

INFORMED CONSENT

I have discussed the treatment and/or treatment plan with the therapist and I consent to allow breast lymphatic drainage/massage therapy for the purpose for which is intended: recovery from surgery, scar improvement, medical breast massage.

Name:_____ Date:_____

Signature: _____