anna scire
massage therapist

Name: _____ Email: _____

Address: _____City: _____State: _____ Zip:_____

D.O.B: _____Occupation: _____Phone: _____

Primary Complain:

_____

_____

Existing medical conditions:

_____

_____

Were you ever diagnosed with cancer? What type? _____

What treatments have you undergone? Did your treatment include any removal of lymph nodes and/or radiation therapy?

Current medication:

_____

_____

Previous injuries, surgeries and when:

_____

_____

Referring Physician: _____

Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days?

NO / YES

Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)?
NO / YES

Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flu-like symptoms within the last 14 days?
NO / YES

I understand that there is a 24hour 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 understand that close contact with people increases the risk of infection from any communicable disease, like the flu or COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner. I agree to hold harmless, release, and indemnify this licensed and certified Massage Therapist against and all liability arising from the application of massage therapy.

Signature: _____ Date: _____