

WELCOME - E KOMO MAI

Coming to a couple's massage?
Please fill out a separate form for each of you.

Client Information

First and last name	<input type="text"/>	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Complete address incl. city, state, and ZIP	<input type="text"/>		
Email	<input type="text"/>	Phone	<input type="text"/>
Emergency contact (name / relationship)	<input type="text"/>	Their Phone	<input type="text"/>
How did you find us?	<input type="text"/>	First Massage?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical and Massage Information

What are your goals for massage? (relaxation, rehabilitation, sport, ...)	<input type="text"/>	Do you have any health conditions or allergies we should know about?	<input type="text"/>
Date of birth	<input type="text"/>	Use the back side to provide more specific information.	
Pressure level	less <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 more	Indicate if pregnant	<input type="checkbox"/> Yes

Liability Waiver and Consent

Initial all

I understand that I am receiving massage treatment at my own risk and agree to hold free the therapist and Hawaii Natural Therapy, LLC, from any claims, demands, or actions including, but not limited to, refunds or claims for personal injury arising from my participation in massage therapy services.

I understand that the massage treatment I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during this and future sessions, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage treatments should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I also understand that massage treatments should not be performed under certain medical conditions.

I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment in full of the scheduled appointment.

I understand that cancelled or missed appointments without 24-hour notice may be charged for the full price of the missed session.

I affirm that I have stated all my known medical conditions and have answered all questions honestly.

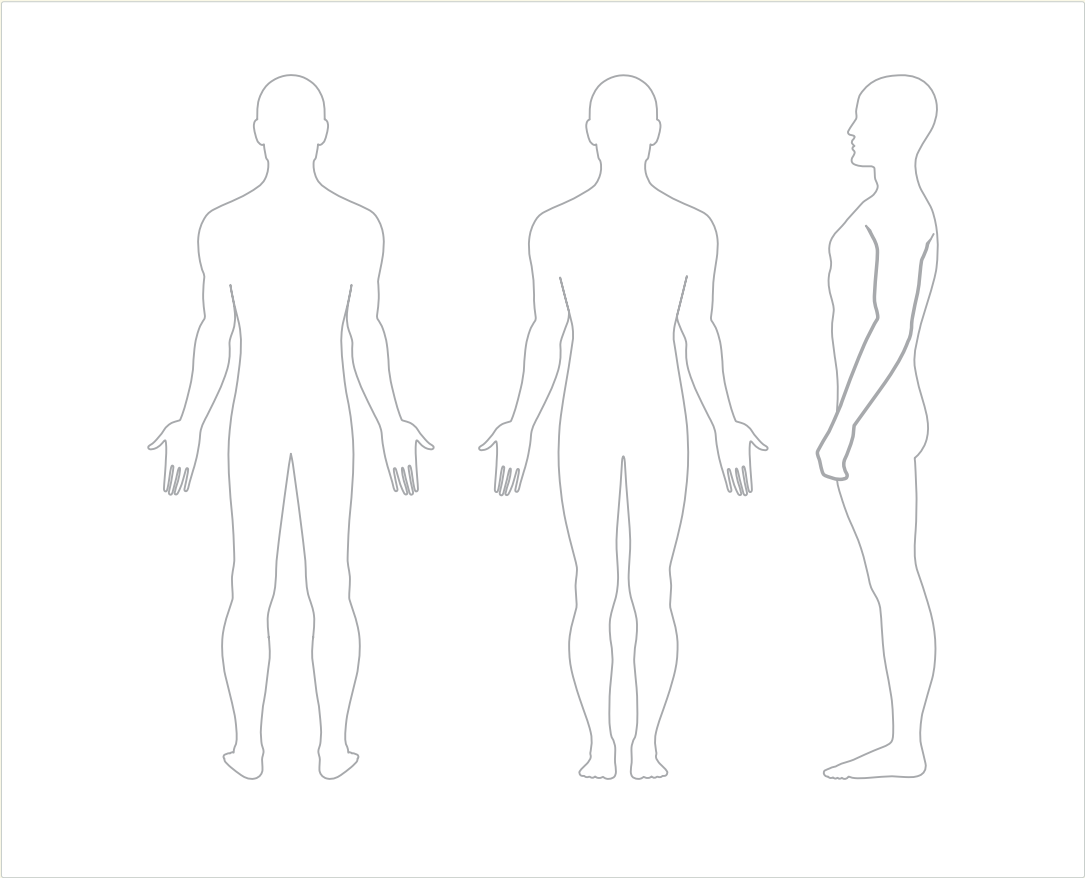
CLINIC USE

Date

Signature

OPTIONAL - Detailed Medical Information

Indicate areas of pain



Additional medical information

A large, empty rectangular box for providing additional medical information.