GLVTE
MASSAGE THERAPY

Indemnity Form

Please print, complete and hand to your GLVTE therapist before your first session. The following form helps the GLVTE therapist understand your personal needs and requirements during your session. Please be as honest you can; all information will be treated as strictly confidential.

1. Have you ever had a professional massage before? Therapeutic/Remedial/Relaxation/Corporate?
2. Which areas would you like focused on during the session? _____
3. Do you suffer from any of the following: (please circle)

• Back Pain	Yes / No	If yes, is it upper / middle / lower back pain?	
• Herniated (slipped) disc	Yes / No	Muscular stress and or/tension	Yes / No
• Neck Problems	Yes / No	Stress	Yes / No
• Hyper/Hypotension	Yes / No	Insomnia	Yes / No
• Heart/Circulatory Problems	Yes / No	Headaches	Yes / No
• Joint Swelling	Yes / No	Numbness/tingling/nerve pain	Yes / No
• Bruise easily Yes/No Depression	Yes / No	Sensitive to touch or pressure	Yes / No

   - Acute or chronic injuries. If yes, please specify:_____
4. Other health concerns/medical conditions not listed: _____

   _____
5. Have you had any major medical problems or surgery in the past 5 years? If yes, please provide further details: _____
6. Are you pregnant? Yes/No. If yes, how many weeks? _____
7. Are you taking any prescribed medication? Yes/No If yes, please list: _____

   _____
8. What would you like to achieve from your sessions?_____

   _____

Agreement: I understand that the massage I receive is provided for the basic purpose of stress reduction & relief of muscular aches and pains. If I experience any pain or discomfort during the session I will immediately inform the therapist so the pressure and techniques may be adjusted to my level of comfort. I understand it is my choice to receive massage therapy and I understand the benefits and risks associated with massage and give my consent. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments and they do not provide medical diagnosis or prescriptions. As massage is contraindicated with certain medical conditions, I affirm that I have stated my known medical history and answered all questions honestly. I agree to keep the massage therapist updated to any changes in my medical profile during the program and understand that there shall be no liability on the therapist part if I fail to do so. I am aware that no medical or other information provided on this form will be shared with a third party without my consent unless required for legal proceedings, criminal proceedings or if the therapist believes my health and/or life is at risk.

Name: _____ Email:_____

Tel:_____ Signed: _____ Date:_____