



DOVER
WOMEN'S
HEALTH

Massage Client Evaluation

Name: _____ DOB: _____ Date of 1st Evaluation: _____

Address: _____ Phone: _____

Nearest Relative/Emergency Contact: _____ Phone: _____

If you are pregnant, please indicate the number of weeks: _____

If you have delivered recently, please indicate how long ago: _____

Medical Conditions (past or present) we should be aware of: _____

Medications: _____

Previous Surgeries (please indicate date): _____

Hobbies / Activities / Interests _____

Have you had previous massage? _____

How was your experience? _____

What are your current goals for massage? _____

Areas of pain, stiffness or discomfort? _____

Areas you do not want to have massaged? _____

The information I have provided is complete and accurate to the best of my knowledge.

Client Signature: _____ Date: _____

Session One: _____

Therapist Signature: _____ Date: _____



Massage Client Policies

- I understand that massage therapy, in all its forms, is offered for the purpose of stress reduction, relief from muscular discomfort, and enhanced circulation.
- I understand that my massage therapist does not diagnose, treat, or prescribe medication for any disease or other physical or mental disorder.
- It has been made clear to me that massage therapy is not a substitute for appropriate, regular, medical care, and that I see a physician for any ailment that I might have.
- With these guidelines in mind, I agree to accept massage therapy for the reasons outlined above.
- I also agree to communicate with my therapist any needs or concerns that I have during my massage.
- I understand that my therapist may refuse to provide massage if he or she believes massage to be unsafe or inappropriate for my current health conditions.
- Payment is accepted when massage services are rendered. The current rate for a 50-minute session is \$60.
- If you are unable to keep your appointment, kindly give as much advanced notice as possible.