

INTAKE FORM

National Massage Therapy Awareness Week

WELCOME! Thank you for your interest in Massage Therapy! Your participation in today's event is greatly appreciated.

Please complete the information below for our records and give it to your Massage Practitioner.

NAME: _____
(Please Print)

AGE: _____ **OCCUPATION:** _____

Are you currently suffering from any ailment which could be affected by today's massage?

If yes, are you currently under a doctor's supervision for this ailment?

Please read the following statement and place your initials and date on the line to indicate that you have read the statement and understand it.

THE AMTA IS NOT RESPONSIBLE FOR THE AGGRAVATION OF CONDITIONS WHICH WERE PRESENT BUT NOT DISCLOSED TO THE PRACTITIONER AT THE TIME OF THE MASSAGE AND WHICH MAY BE AFFECTED BY THE MASSAGE.

Signature

Date

DO NOT WRITE INSIDE THIS BOX – PRACTITIONER USE ONLY

PRACTITIONER NAME:

PC