# AROMATHERAPY CONSENT FORM

| Name | Date |
|---|---|
| | |

## HEALTH HISTORY

Please check all current / past conditions that apply:

| | | |
|---|---|---|
| ☐ asthma | ☐ high blood pressure | ☐ epilepsy |
| ☐ cardiac issues | ☐ low blood pressure | ☐ photo toxicity |
| ☐ acute lung/respiratory issues | ☐ active cancer (ask for an Oncology Intake form) | |

Have you had aromatherapy services before or used aromatherapy products before?
☐ Yes ☐ No If yes, please explain any previous complications or problems with aromatherapy:

Are you receiving homeopathic treatments?
☐ Yes ☐ No

| Are you pregnant or trying to become pregnant? | Are you breast feeding? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

Do you have any allergies and/or skin sensitivities?
☐ Yes ☐ No

Our lotion products may contain nut oils. Are you allergic to nuts or nut products?
☐ Yes ☐ No If yes, please list the types of nuts:

Are there any additional medical issues we should know about?
☐ Yes ☐ No If yes, please explain the medical issue:

If you have an issue you do not wish to state on this form, please discuss it with your therapist.

Please list any conditions or side effects you have and/or medications you are taking associated with these conditions:

***IF YOU HAVE ANY OF THE ABOVE CONDITIONS, PLEASE PRESENT A PHYSICIAN'S WRITTEN CONSENT PERMITTING YOU TO RECEIVE AROMATHERAPY SERVICES.***

## TERMS & CONDITIONS

***BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING:***

***I have completed this Aromatherapy Consent Form to the best of my knowledge. I understand that massage sessions with aromatherapy do not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide the best massage care. If I am having or develop any complications during a message session with aromatherapy, I will discuss them with my massage therapist.***

I hereby voluntarily release Operator dba Elements Massage™, Elements Therapeutic Massage, LLC, the franchisor of the Elements Massage™ franchise system, its and their affiliates and their respective shareholders, members, principals, owners, officers, directors, employees, agents, representatives, successors, and assigns from all claims, costs, demands, expenses, and causes of action should my condition be aggravated at any time. By signing below, I agree that I have read the information above and have decided to receive massage sessions with aromatherapy at my own risk.

***Name of Studio Operator:*** Element Therapeutic Massage Woodridge ***("Operator")***
***Studio Address:*** 1001 W 75th St, Woodridge, IL 60517 ***("Studio")***

| Signature | Print Name | Date | MT Initials |
|---|---|---|---|
| | | | |

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