



Please take a moment to carefully read the following information and sign where indicated.

If you have a medical condition or specific symptoms, massage therapy may be problematic for you. A referral from your primary health care provider may be required prior to treatment being provided.

- I understand that the massage therapy provided by Sabrina Roberson of Moon Cycle Arts is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.
- If at any point during the massage I am uncomfortable or uneasy with the procedures being administered and/or if I experience pain, I understand it is my responsibility to IMMEDIATELY inform the massage therapist, so that the massage can be terminated or the strokes and pressure can be adjusted to a level of comfort.
- I further understand that massage therapy is not a substitute for a medical examination, diagnosis, or treatment, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have.
- I have informed the massage therapist of all my known physical conditions, medical conditions and current medications, and I will keep the massage therapist updated on any changes for future sessions.
- I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information about my health or condition.

1. Prior to a massage, remove all jewelry.

2. Please provide feedback as to pressure (deeper or lighter) and discuss painful or ticklish areas of your body.

3. Feel free to ask questions about the procedures. The massage therapy provider is well trained, ethical, and professional and will be happy to make you feel well informed and comfortable.

4. Keep all changes to the medical health profile updated, neglecting to report health care changes may result in the termination of future treatments.

5. Any illicit or sexually suggested remarks or advances will result in immediate termination of the treatment.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____