AIKANA ESTHETIC CENTER
6569 Edsall Rd. Springfield VA, 22151

MASSAGE CONSENT FORM

Massage: | **Today's date:** _________________

☐ Post-Operative Treatment ☐ Body Sculpting/Detox

Name (Print Clearly):____ Birth Date: ____________________
Cell Phone: _______________________ Email: ____
In Case of Emergency: ____ Phone: ________________________
Primary Care Physician: ____ Phone: ________________________
Home address:_______________________________________ City_____________ State_________Zip_______
How did you find us? ☐Google ☐Yelp ☐Instagram ☐Facebook ☐Flyer ☐Friend ___________________________
Please describe the reason of your visit including where it is and its severity: _________________________________
____
Are you currently undergoing cancer treatments: ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Personal Past History of Illnesses: (Please, circle if applies)

Arthritis / Joint Problems /Heart Attack Problems /Asthma High / Blood Pressure /Aneurysm /HIV /AIDS /Diabetes /Back Problems/ Kidney Infections / Stones /Bowel Problems / Liver Disease/ Broken Bones/ Migraine Headaches /Cancer (any kind) /Osteoporosis /Circulation Problems /Pneumonia / Lung disease /Collagen Vascular Disease (Lupus) /Rheumatic Fever /Convulsions Epilepsy Stroke /Deep Vein Thrombosis Thyroid Disease /Depression /Anxiety / Seizures /Tuberculosis Other: ____
Current medications (Including hormones, vitamins, herbs, non prescription medications):
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Surgical History:

LIPOSUCTION (Circle) : Upper Abdomen / Lower Abdomen / Flanks / Lower Back / Upper Back / Thighs / Arms
FAT TRANSFER (Circle): Breast / Buttocks / Hips /
SKIN REMOVAL (Circle): Tummy Tuck & Muscle Repair / Extended Tummy Tuck / Back / Thigh / Arms / Abdomen
Date: ___________________

Dr. ______________________________ Location: ______________________ Contact: _______________________
Other past Procedures that we should know, mention dates) ____
____

I understand that the Massage/Treatment I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.
I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Disclosure: *The personal data that you provide us will only be handled by Aikana Esthetic Center (Pur Beauty LLC) or any of our marketing providers but only for exclusive uses related to our services and our company. This information won't be provided to any third party, by signing this form, you allow Aikana Esthetic Center to contact you either by text, email or call.*

Client Signature ___________________Practitioner Signature _______________________

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Risk Waiver

I,_________________________ (patient name) understand that I am opting for an elective treatment/ procedure that is not urgent and may not be medically necessary. I understand that all treatments/ procedures run with risk.

DOWN BELOW I AM DISCLOSING ANY ALLERGIES OR CONDITIONS:

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Please read ALL the following statements and initial all the statements:

▪______ Clients who are post surgical are prone to dizziness, nausea and drops in blood pressure due to their current operations and are aware that Aikana is not responsible for their bodies reaction to their physical state.

▪ ______ Pur Beauty LLC (Aikana Esthetic Center) performs Post-Operative Treatments that stimulate the lymphatic system and can occasionally cause incisions to reopen which aids in the draining process.

▪ ______ Pur Beauty LLC (Aikana Esthetic Center) will occasionally use a mixture of hand massage and different tools to help get better results. The tools are universal and can be used on all of our clients. These tools can cause temporary bruising, boils, rashes, and small scratches on clients with more sensitive skin.

▪______ I understand that I may be unable to proceed with certain procedures From Pur Beauty LLC if the procedures are deemed unsafe to myself or a staff member. I will inform staff members of any of my concerns .

• I understand that the staff at Aikana Esthetic Center (Pur Beauty LLC) will do everything possible to minimize any unwanted reaction or side effects to my visit. Pur Beauty LLC (Aikana Esthetic Center) is not responsible for Side effects from my treatments.

Patient Name: __________________________
Patient Signature: _______________________
Date:_____________