

# Tantric Flow

Name:

Age:

## **Medical Declaration:**

Do you suffer from or have suffered from any of the following? (PLEASE TICK)

High or low Blood Pressure?

Diabetes?

Cancer?

Epilepsy?

Recent haemorrhage?

Thrombosis or embolism?

Lumps/swelling?

Skin disorders/scalp infections?

Allergies/sensitive skin?

Spastic conditions (e.g. muscular spasms)?

Recent operations?

Fluid retention

Discomfort/pain in your body?

Anxiety/depression?

Dysfunction of the nervous system (e.g. Parkinson's disease)?

Heart condition?

Liver complaints (e.g. hepatitis)?

Varicose veins?

Digestive problems (e.g. irritable bowel syndrome)?

Nut Allergy?

Any other health problems or recent illnesses?

Any area's I should avoid? (Cuts, abrasions or bruising)

## **Client Declaration & Waiver**

I hereby give my consent to receive a tantric massage which includes genital and intimate touch.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes.

By signing this, I hereby waive, release, discharge Tantric Flow from any and all liability, for any and all injuries, including damages, or claims relating to or resulting from my tantric massage.

Print name \_\_\_\_\_ Sign \_\_\_\_\_ Date \_\_\_\_\_