Client Information

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email: _____ Cell Phone: _____

Referred by: _____ Cell Phone Carrier: _____

In case of emergency: _____ Phone (_____) _____

General & Medical Information

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible below in comments.

Physical Conditions

❑ Yes ❑ No Do you have cardiac or circulatory problems (including blood clots)?
❑ Yes ❑ No Do you have numbness or stabbing pains anywhere?
Please specify_____
❑ Yes ❑ No Do you suffer serious allergic reactions?
Please specify_____
❑ Yes ❑ No Do you suffer from Arthritis/ bursitis?
Where?_____
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you suffer from joint swelling?
Where?_____
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Are you pregnant? How many months?_____
If you are in your first trimester we are not able to perform a massage without a physician's release.
❑ Yes ❑ No Do you have a pacemaker/body implants?
Please Specify_____
❑ Yes ❑ No Do you experience frequent headaches/migraines?
❑ Yes ❑ No Do you suffer from chronic stress?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Are you currently being treated by a physician for any other medical conditions or taking any medications I should know about?
Please specify_____

Diseases

❑ Yes ❑ No Do you have any contagious diseases?
If so, please specify_____
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No If "yes" to previous question, is it controlled by medication?
❑ Yes ❑ No Do you have eczema/psoriasis/skin diseases?
❑ Yes ❑ No Do you have Diabetes?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you have a foot or nail fungus?
Please specify _____

Injuries/Surgeries

❑ Yes ❑ No Have you suffered any broken bones?
How recently?_____
❑ Yes ❑ No Have you recently been in an accident or suffered any serious injuries?
Please specify_____
❑ Yes ❑ No Have you had any recent surgeries?
Please specify_____

Skin Care Specific

❑ Yes ❑ No Have you had a professional spa facial, microdermabrasion, medical peel or waxing before?
If so, how often?_____
How recently? _____
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you use Retinol, Retin A, Restylane?
❑ Yes ❑ No Have you had treatment by a dermatologist?
How recently?_____
Please Specify _____

Massage Specific

❑ Yes ❑ No Have you experienced a professional massage or bodywork session?
If so, how often?_____
How recently?_____
What kind?_____
❑ Yes ❑ No Are there any specific areas you would like the therapist to address._____
❑ Yes ❑ No Are there any specific areas you would like the therapist to avoid._____
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area? Please specify_____
❑ Yes ❑ No Do you want the therapist to work on your hips/glutes?

I understand that the massage/bodywork and spa treatments I receive are provided for the basic purpose of relaxation and relief of stress and muscular tension and self care. **If I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so that the treatment may be adjusted to my level of comfort**. I further understand that massage, bodywork and other spa services 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 spa treatments 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.

Client Signature _____ **Date** _____

Consent to Treatment of Minor*: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary. Minors under 18 require the guardian to be present in the treatment rooms.*

Signature of Parent or Guardian _____ *Date* _____