Massage Client Information

Referred By:_____

Date:_____

Please turn your cell phone to slient. Please answer all of the following questions to ensure that you have a safe and enjoyable experience.

First Name: _____ M.I. _____ Last Name:_____

Address: _____City:_____ State: _____ Zip: _____

Phone(h): _____ (w) _____ Date of Birth: _____

Employer: _____Occupation: _____

Emergency contact: _____ Phone:_____ Relationship:_____

You are here today because (please check one or more):

_____ Gift (from whom _____

_____ Treat to Self

_____ Regular Maintenance

__ ___ Health Reasons (explain: _____

_____ Stress Reduction ____ Other (If yes please explain)

_____

Please Circle your service yo are scheduled today.

Relaxation Massage Aromatherapy Massage Deep Tissue Massage Hot Stone Massage Thai Massage

Mommy To Be Massage Escape Pedicure Spray Tanning Body Scrubs/Treatments Xtreme Lash Extentions

Are you currently under the care of a physician? _____ If "Yes" whom? _____

Please state any recent injuries, surgeries, accidents or recent medical diagnosis:

_____

List ***ALL*** medications you are currently taking (including "over the counter"): _____

Water Intake _____ How active are you (excercise regimen) _____

We strive for hypoallergenic products however even some natural products can cause allergic reactions. Please list any we need to be aware of : _____

Circle any conditions you've had in the past or present.

neck/spinal injury Back Pain Sciatic Leg Pain Carpal Tunnel TMJ Syndrome Sports Injuries Headache Varicose Veins

High Blood Pressure Low Blood Pressure Skin Disorders Infectious Dieseases Diabetes Arthritis Fibromyalgia

Grief Process Liver Ailment Kidney Ailment Cold/Flu/Fever Cancer PMS Syndrome Other:_____

Are you pregnant? _____ If yes when are you due?

Do you have any sensitivity to heat or cold?_____
Do you have any sensitivity to smells or scents? _____

The above information is accurate and true to the best of my knowledge. I understand that all therapists, estheticians or other professionals that I may see today are licensed and working within their scope of practice. I, also, understand that my practitioner does not diagnose disease, prescribe medications or manipulate bones. I agree to pay for my treatment at time of service unless otherwise arranged. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I have read and understand the policies of this establishment fully.

Signature:_____Date:_____