# Spa Client Information

Name_____ Phone ( _____ ) _____ DOB_____

Address _____ City_____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone ( _____ ) _____

In case of emergency: _____ Phone ( _____ ) _____

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.**

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you have a thyroid condition?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Are you wearing contact lenses or dentures?
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you have high blood pressure and/or take medication to manage blood pressure?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you suffer from back pain or disk herniation?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery?
❑ Yes ❑ No Other medical condition, or are you taking any medications?

Comments _____

_____

_____

Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently?_____

What are your goals for today's treatment?_____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm

I understand that the massage/bodywork/spa treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment, 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____Date _____

Practitioner 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.

Signature of Parent or Guardian _____Date_____