Client Information Form

SPA in the WOODS

Name _____

Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Cell Phone Provider _____

Email _____

Occupation _____ Spouse _____

Referred By _____ Physician _____

Please Circle Yes or No and elaborate where needed

Have you ever had a professional massage before? ..... Yes No

Do you wear contact lenses or dentures? ..... Yes No

Do you take any prescribed medication? ..... Yes No

Do you suffer from sinus, migraines or TMJ? (circle all that apply) ..... Yes No

Do you have any varicose veins or blood clots? ..... Yes No

Do you have arthritis? ..... Yes No

Do you exercise regularly or participate in any sports? ..... Yes No

If yes what kind and how often? _____

Do you have any heart problems? ..... Yes No

Do you have any spinal problems? ..... Yes No

Do you have any bowel or digestive problems? ..... Yes No

Do you have any infectious diseases? ..... Yes No

Do you have high blood pressure? ..... Yes No

Have you ever had cancer? ..... Yes No

Have you suffered from an acute injury recently? ..... Yes No

Do you have any skin problems allergies planters warts or athletes foot? (Circle all that apply)

Do you have any tense or sore areas that need special attention? ..... Yes No

If yes please specify: _____

Do you have any medical condition that I should be aware of before giving you massage therapy? ..... Yes No

If yes please specify: _____

Preferred pressure (please circle one) light medium heavy

Authorization

I, _____ understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment of pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitution for a medical examinations and / or diagnosis and that it is recommended that I see a physician for any physical ailment. Because a massage therapist must be aware of existing physical condition, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____

Prenatal Authorization

I, _____ take full responsibility for myself and my baby. I have consent from my doctor to receive this service. I will keep the therapist up to date with any changes in our health.

Prenatal Authorization

Parental consent authorization _____

Minors under the age of 17 must have written consent or be accompanied by a parent/guardian.

Mark an X to indicate sore or tense areas.