

PURE SPA

MESSAGE CLIENT INFORMATION FORM

NAME _____

ADDRESS _____

PHONE _____ HOME

_____ CELL

EMAIL _____

BIRTHDAY ____/____/____

OCCUPATION _____

HOW DID YOU HEAR ABOUT US? _____

DID SOMEONE REFER YOU TO US? IF SO, WHOM? _____

I, _____, understand that massage therapy is provided for stress reduction, relief from muscular tension or spasm, 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 or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing conditions, I have stated all my known medical conditions on the reverse side of this form, and take it upon myself to keep the massage therapist updated on my physical health.

SIGNATURE _____ DATE _____

If under 18 years of age, a parent's signature is required. _____

Massage Clients, please continue onto the back for remainder of form.

COMPLETING THIS FORM WILL HELP THE THERAPIST PLAN YOUR COURSE OF TREATMENT

PRIMARY PROBLEM/REASON FOR THIS APPOINTMENT _____

IF RELATED TO ACCIDENT / INJURY: DATE OF INCIDENT _____

DESCRIBE INCIDENT BRIEFLY _____

WHAT MAKES CONDITION BETTER? _____ WORSE? _____

HOW WOULD YOU DESCRIBE YOUR STRESS LEVEL? _____

EXERCISE: TYPE _____ HOW OFTEN _____

HAVE YOU HAD PROFESSIONAL MASSAGE BEFORE? YES NO

WHAT RESULTS DO YOU WANT FROM YOUR MASSAGE SESSION? _____

MEDICATIONS, REMEDIES AND/OR SUPPLEMENTS YOU ARE TAKING _____

DO YOU WEAR CONTACT LENSES? YES NO

Please check any of the following conditions that you are currently experiencing or have recently experienced:

MUSCULOSKELETAL

- ___ arthritis
- ___ osteoporosis
- ___ TMJ dysfunction
- ___ sciatica
- ___ hernated disk
- ___ bursitis
- ___ tendonitis
- ___ other _____

ALLERGIES _____

SENSITIVITY TO LOTIONS/
 OILS _____

SKIN CONDITION _____

CIRCULATORY

- ___ varicose veins
- ___ blood clots
- ___ high blood pressure
- ___ low blood pressure
- ___ phlebitis
- ___ arteriosclerosis
- ___ aneurysm
- ___ easy bruising
- ___ chest pain
- ___ heart condition _____
- ___ other _____

DIGESTIVE ISSUES _____

ARE YOU PREGNANT? _____

MISCELLANEOUS

- ___ cold hands/feet
- ___ numb hands/feet
- ___ headaches/migraine headaches
- ___ fatigue
- ___ insomnia
- ___ sinusitis
- ___ dizziness/fainting
- ___ cold or flu
- ___ shortness of breath
- ___ severe depression
- ___ diabetes
- ___ cancer
- ___ hepatitis
- ___ nerve pain
- ___ recent internal bleeding
- ___ recent surgery _____
- ___ other _____

Please indicate with an "X" on the drawings to the right your areas of discomfort, especially areas of tension.

Is there any part of the body you prefer not to be massaged? (i.e. head, feet, etc) _____



