Confidential Client Information Form

Name: ____ Birth Date: _______________

Address: ____

City/State: ____ Zip Code: ___________________

Home Phone: ____________________ Work Phone: ___________________ Pager/Cell #: ______________

Email: ____ Occupation: _______________

Emergency Contact: Name:_______________________________________ Phone: __________________

Reason for Session: ____

What type of regular physical activity do you participate in? ____

Have you ever received a professional massage? Yes ____ No ____ Frequency: ________

How did you hear about us? ____

Medical History: Please explain on the back of this page any areas checked below.

	Hypertension		Cancer/malignancy		Edema/ Swelling		Abscess or open sore
	Heart Disease		Diabetes		Herniated Disc		Easy Bruising
	Varicose Veins		Fibrosis		Inner ear problem		Headaches
	Phlebitis		PMS/ painful menses		Currently pregnant		Skin sensitivity
	Epilepsy		Contact lenses		Thrombosis/ embolism		Allergies
	HIV/ AIDS		Rheumatoid arthritis		Inflammations		Skin Rash

Please list any other conditions, recent surgeries, injuries, indications for and contraindications to this massage.
____
____

Areas of complaint, pain, or tension: ____

Are you currently seeing a health practitioner? _________ For what condition? ___________________________

List any medications you are taking: ____
(include prescriptions, over-the-counter medications and supplements)

Do we have permission to contact your physician should the need arise? Yes ____ No ____

Physician's Name: ____ Phone: ______________________

Client Commitment

I understand that massage is not a substitute for medical examination or diagnosis. I agree to receive a massage/spa service and realize that the treatment is being given for the well being of my body and mind. I understand that I have the following responsibilities:

- To communicate to the therapist if I am in physical or emotional pain.
- To request to stop if I feel like my well-being is compromised in any way.
- To participate in setting goals for each session and evaluating them.
- To call to cancel appointments as soon as I know I cannot come.
- To keep therapist updated on medical conditions, and release the therapist from liability if I fail to do so.

I also understand and agree that if I make any illicit of sexually suggestive remarks or advances, or if I exhibit any sexual misconduct. I will be liable for payment of the full session, the session will end immediately, and I will not be allowed to receive massage at EXHALE Spa Escapes in the future.

SIGNATURE: ____ Date: _______________