Massage Therapy Client Profile

Name:_____ Date of Initial Visit_____

Address:_____

City, State, Zip:_____

Phone: Cell:_____ Home:_____

Email:_____

Date of Birth:_____ Referred By:_____

Occupation:_____

Employer:_____

Is the expectation of the massage? (check one) Therapeutic_____ Relaxation_____

1. Have you ever had Massage Therapy before? Yes_____ No_____

2. Do you have difficulty lying on your front, back, or side? Yes_____ No_____

3. Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? Yes_____ No_____

If yes, please explain_____

4. Women: Are you pregnant? Yes_____ No_____ If yes, how many months?_____

5. What is your major complaint, if any that you want to improve?

_____

_____

6. When did you first notice this issue?_____

7. What event(s) brought it on and what activities aggravate the condition?

_____

_____

8. What have you tried to get relief from the issue?

_____

_____

9. Are you currently under the medical supervision of:

Chiropractor_____ General Practitioner_____

10. Are you currently taking any medications? Yes_____ No_____

If yes, please list:

_____

_____

Check the following conditions that apply to you, past and present.
Please add your comments to clarify the condition.

___Cancer: Current_____ Remission_____

____Diabetes	_____Headaches		
____Broken/fractured	_____Menopause	_____Strains and sprains	_____Lymphedema
____Tendonitis	_____ Bursitis	_____ Rashes	_____Arthritis
____Osteoporosis	_____Fibromyalgia	_____Fainting	_____Heart Condition
_____Sinus Problem	_____Spinal cord injury	_____High Blood pressure	_____Low blood pressure

_____Other_____

Surgeries:_____

Please list any additional comment regarding your health and wellbeing:_____

_____

All of the above information is correct to the best of my knowledge. I realize that this session is not intended to diagnose or treat any condition that I may have, and is purely for therapeutic purposes. I will not hold the Massage Therapist liable for any exacerbated condition that was not disclosed in the above questionnaire.

Signature:_____ Date:_____

CLIENT CONSENT FORM

I, _____(please print), understand that spa and salon services provided by the Calla Lily Day Spa and Salon are intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

I am aware that the technician does not diagnose illness or disease, and does not prescribe medications. I am also aware that spinal manipulations are not part of massage therapy.

I will inform the technician of all my known physical conditions, medical conditions, and medications, and I will keep the technician updated on any changes. I understand that the Calla Lily Day Spa and Salon is not responsible for any injuries or illness that may be caused because of withheld information.

Client Signature Date

_____ _____