

Massage at the Lake Day Spa

Name: _____ Phone Number: _____ DOB: ____/____/____

Address: _____

Email: _____ Referred by: _____

Emergency Contact: _____ Phone Number: _____

Please take a moment to answer the following questions and sign where indicated.

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

Yes No Do you have diabetes? Yes No Have you recently had surgery?

Yes No Do you experience frequent headaches? Yes No Do you suffer from back pain?

Yes No Do you suffer from arthritis? Yes No Do you have high blood pressure?

Yes No Do you suffer from joint swelling? Yes No If yes, do you take medication for this?

Yes No Do you have varicose veins? Yes No Do you suffer from epilepsy or seizures?

Yes No Do you have osteoporosis? Yes No Do you have any contagious disease?

Yes No Do you bruise easily? Yes No Do you have allergies?

Yes No Do you have cardiac or circulatory problems? Yes No Have you been in an accident or suffered any injuries including broken bones in the past two years?

Yes No Do you have numbness or stabbing pain anywhere? Yes No Do you have any other medical condition or take any medication I should know about?

Yes No Do you have tension or soreness in a specific area? Please Specify: _____

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any discomfort during this session, I will inform the practitioner so that the pressure can be adjusted to my level of comfort. I 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 signing below, I authorize the above client to receive professional massage services.

Signature of Parent or Guardian: _____ Date: _____