SPA WITHIN

Massage Consultation Form

Client Name:	Phone Number:
Address:	Cell Number:
Please indicate: ❑ Male ❑ Female	Email:

Do you have known allergies? Y N If yes, what are they?

Are you presently taking any medications Y N
If yes, please specify:

When was your last complete physical examination?

General Health History

The following questions pertaining to your overall state of health are nonetheless necessary an any manipulation of body tissue will have some consequences and in certain circumstances even the slightest manipulation is considered inadvisable.

It is recommended that all clients who receive a massage drink at least 8 glasses of water afterwards to help flush out any toxins that have been released within the body as well to not engage in strenuous activities. If at any time this massage becomes inadvisable it will be discontinued.

The following is a list of contraindications to receiving a body massage which will make this massage appointment inadvisable or may result in certain body areas not being massaged. Please indicate if any are applicable to you. Your Therapists will review with you.

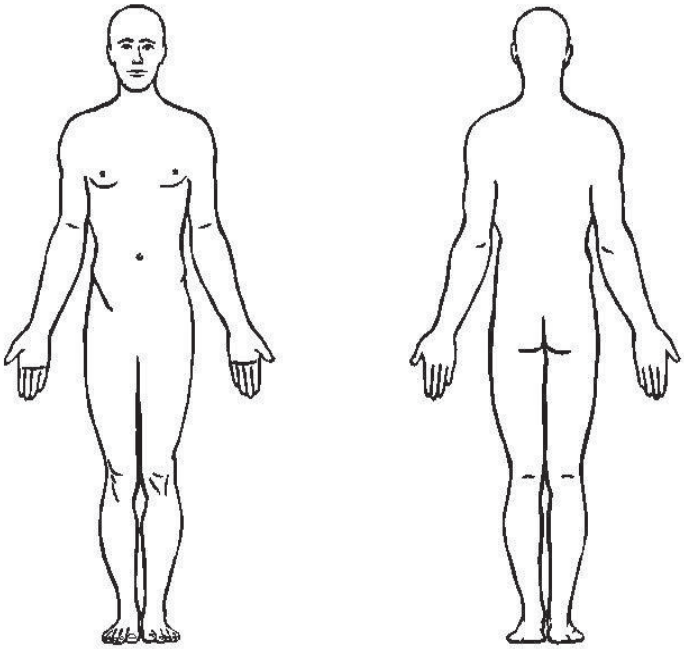
	Y	N	Comments
Fever	❑	❑	
Contagious Illness	❑	❑	
Edema with Pregnancy	❑	❑	
Suspicious Growths/Moles	❑	❑	
Open Wounds and Bruises	❑	❑	
Cancer/History of Cancer	❑	❑	
Active Herpes	❑	❑	

The following is a list of cautionary conditions which Therapists need to be aware of in order to provide you with the safest possible massage session. Please indicate if any are applicable to you. Your Therapists will review with you.

	Y	N	Comments
High Blood Pressure	❑	❑	
Varicose Veins	❑	❑	
Circulatory Disorders	❑	❑	
Respiratory Disorders	❑	❑	
Digestive Disorders	❑	❑	
Pregnancy	❑	❑	
Diabetes	❑	❑	
Osteoporosis/Arthritic Conditions	❑	❑	
Inflammation	❑	❑	

Additional Comments:

Special Conditions/Concerns:



Acknowledgement	
I, the undersigned, have accurately filled out the above consultation bringing attention to any specific conditions or concerns. I understand the reason for this and I am aware that all discussions are confidential. I agree not to hold the practitioner or any associated party responsible for any problems occurring after my treatment based on misinformation or lack of information I have given.	
Customer Signature:	Date:
Therapist's Name:	Date:

Client Follow-up Sessions

2nd Therapist's Name (Print):	Date Reviewed:	Comments:	Client Initials:
3rd Therapist's Name (Print):	Date Reviewed:	Comments:	Client Initials:
4th Therapist's Name (Print):	Date Reviewed:	Comments:	Client Initials:
5th Therapist's Name (Print):	Date Reviewed:	Comments:	Client Initials:
6th Therapist's Name (Print):	Date Reviewed:	Comments:	Client Initials: