

Almost Eden Home Spa

Client Information

Name _____ Phone _____ Birthdate _____

Address _____ City _____ State _____ Zip Code _____

Emergency Contact

Name _____ Phone _____

Address _____

Relationship _____

Doctor's Name _____ Phone _____

Have you ever had a professional massage session? yes no

Were you referred by anyone? yes no Whom? _____

Are you interested in: Wellness/relaxation massage Therapeutic massage

List current medications you are taking. Please include any muscle relaxants or blood thinners.

Medication	Prescribed for:

Previous Medical History

Skin Disorders _____

Major Surgeries (with dates) _____

Broken Bones (with dates) _____

Injuries / Accidents that are still affecting you _____

Allergies to nuts, oils, creams? yes no Please describe: _____

Please list any spine or back injuries. Include any disk problems (bulging, ruptured, herniated) and the location. Also, any treatments you are currently undergoing for these.

PO Box 506 - 7709 12th Street - Somers WI 53171
262-497-8583 262-859-0369 Fax
almostedenhomespa.com

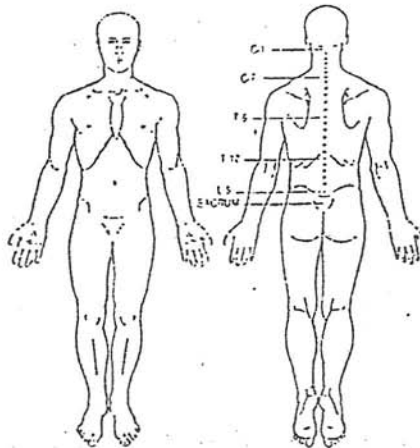
Please mark any of the following that you have and circle if you presently have.

- | | | |
|--|--|---|
| <input type="checkbox"/> Bone or Joint Disease | <input type="checkbox"/> Arthritis, Bursitis or Gout | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Hip/Leg Pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High/Low Bloodpressure | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Anxiety/Stress | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin | <input type="checkbox"/> Cancer | <input type="checkbox"/> Varicose Veins |

HIV/Aids* Hepetitis Type*
(*Please note gloves may be worn to protect both therapist and client)

Additional Client Remarks / Comments

Please Indicate with an X on the drawing below the places are feeling discomfort today.



I understand that a massage therapist neither diagnosis illness, disease or any other medical physical or emotional disorder, nor performs any spinal manipulations. I know that I must keep my massage therapist informed of any changes in my medical profile and understand that there is no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggested remarks or advances made by me will result in termination of my session, and I will still be liable for payment.

Client Signature _____ Date _____

Consent to treat ment of a Minor: By my signature below, I authorize _____
to administer massage thera^y to _____ my minor child.

Signature of Parent / Guardian _____ Date _____