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 presenlty have.

___ Bone or Joint Disease	___Arthritis, Bursitis or Gout	___ Sprains
___ Mid Back Pain	___ Low Back Pain	___ TMJ/Jaw Pain
___ Neck/Shoulder Pain	___ Hip/Leg Pain	___ Osteoporsis
___ High/Low Bloodpressure	___ Heart Condition	___ Blood Clots
___ Headaches/Migraines	___ Anxiety/Stress	___ Fibromyalgia
___ Diabetes ___Insulin	___ Cancer	___ Varicose Veins

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

Additional Client Remarks / Comments

_____

_____

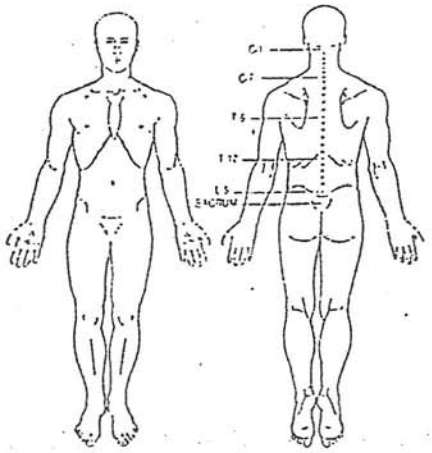
_____

_____

_____

_____

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 theray to_____my minor child.

Signature of Parent / Guardian_____Date_____