

# MASSAGE CLIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I would like to receive offers and updates via email.  Yes  No, thanks

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Primary Care Physician and phone number: \_\_\_\_\_

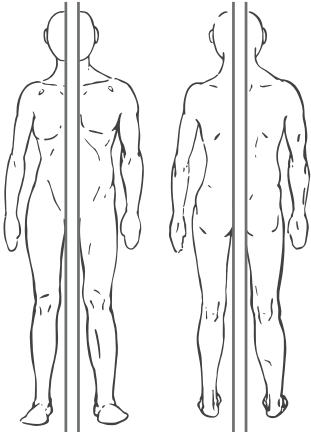
How did you hear about our spa? (please select one)  Sign on building  FAC  Magazine / Printed Ad

Friend or Relative  Returning Customer  Other: \_\_\_\_\_

Please check below if you have, or have had, any of the following:

On the image below, please circle areas of discomfort we should know about or pay extra attention to:

- |   |   |  |
|---|---|--|
| <input type="radio"/> High Blood Pressure           | <input type="radio"/> Muscle sprain / strain  | <input type="radio"/> Skin Rash              |
| <input type="radio"/> Varicose Veins / Clots        | <input type="radio"/> Phlebitis               | <input type="radio"/> Open Wound/ Sore       |
| <input type="radio"/> Tumors / Cysts                | <input type="radio"/> Cancer                  | <input type="radio"/> Insect/Animal Bite     |
| <input type="radio"/> Skin Conditions               | <input type="radio"/> Diabetes                | <input type="radio"/> Severe Pain            |
| <input type="radio"/> Arthritis                     | <input type="radio"/> Heart Conditions        | <input type="radio"/> Cold / Flu             |
| <input type="radio"/> Scoliosis / Spinal Injuries   | <input type="radio"/> TMJ                     | <input type="radio"/> Anything Contagious    |
| <input type="radio"/> Head Injury                   | <input type="radio"/> Headaches               | <input type="radio"/> Injuries or Bruises    |
| <input type="radio"/> Neck injury / Whiplash        | <input type="radio"/> Back pain               | <input type="radio"/> Contact Lenses         |
| <input type="radio"/> Broken Bones                  | <input type="radio"/> Allergies               | <input type="radio"/> Hearing Aid            |
| <input type="radio"/> Seizures                      | <input type="radio"/> Recent Surgeries        | <input type="radio"/> Prosthetic Device      |
| <input type="radio"/> Now Pregnant or Breastfeeding | <input type="radio"/> Removable Dental Device | <input type="radio"/> Brace for support/pain |



If you checked any of the above or have an unlisted condition or concern, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a massage before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

I understand that the massage/treatment I receive is for the basic purpose of relaxation and enjoyment. I understand that massage is not a substitute for medical treatment or diagnosis. I have stated all my known medical conditions honestly. I understand that the Revive Day Spa reserves the right to refuse massages/treatments if determined to be unsafe for me due to any current or past medical conditions. Should I need to cancel future sessions, I agree to give full 24-hour notice to the Revive Day Spa or I will be financially responsible for the session time. I freely give my permission to be massaged.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

