



HEALTH INFORMATION

Name _____ Phone (____) _____ DOB _____

Address _____ City/State _____ Zip code _____

E-mail _____

Employer/Occupation _____ Phone (____) _____

How did you hear about us? _____

In case of emergency _____ Phone (____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork maybe contraindicated. A referral from your primary care provider maybe required prior to service provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you have a thyroid condition?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

HEALTH INFORMATION

Yes No

Do you suffer from arthritis?

Yes No

Are you wearing contact lenses or dentures?

Yes No

Do you have cardiac or circulatory problems?

Yes No

Do you have high blood pressure and/or take medication to manage blood pressure?

Yes No

Do you suffer from epilepsy or seizures?

Yes No

Do you suffer from joint swelling?

Yes No

Do you have varicose veins?

Yes No

Do you have any contagious diseases?

Yes No

Do you have osteoporosis?

Yes No

Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)?

Yes No

Do you bruise easily?

Yes No

Any broken bones in the past two years?

Yes No

Any injuries in the past two years?

Yes No

Do you suffer from back pain or disk herniation?

Yes No

Do you have numbness or staving pains?

Yes No

Are you sensitive to touch or pressure in any area?

Yes No

Have you ever had surgery?

Yes No

Other medical conditions, or are you taking any medications?

Comments _____

HEALTH INFORMATION

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

What are your goals for today's treatment? _____

What kind of pressure do you prefer? ___ light ___ medium ___ firm ___

✓ Client Signature _____ Date _____

✓ Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

CONTRACT FOR CARE

I promise to participate fully as a member of my healthcare team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my healthcare team. I will report on all suggestions for my massage treatment made by physicians, physical therapist and chiropractors to BLU HEALING SPA. I promise to inform my massage therapist any time I feel discomfort or that my well-being is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.

CONSENT FOR CARE

It is my choice to receive massage therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my massage therapist of any changes in my health.

✓ PRINT NAME _____ DATE _____

✓ SIGNATURE _____