Cynthelese Massage Spa

CLIENT INFORMATION FORM & INFORMED CONSENT

Date: _____/_____/_____

CLIENT # _____

Please take a moment to complete our client profile. The following information will enable us to recommend the best procedures, therapies and treatments, as well as the appropriate home care products. Any information you provide will be kept confidential.

Referred By? _____

If available would you like to receive CynthSpa news and special offers by (Check all that apply) □ Email □ Text □ Social media □ Mail □ None

If available would you prefer your reservation confirmations by: Phone □ Yes □ No and/or Email □ Yes □ No

Name: Mrs. / Ms. / Mr. _____

Address: _____

City: _____ State: _____ Zip Code: _____
Cell Phone: (____) _____ Best Contact number other than cell: (_____) _____
Email: _____

Date of Birth: _____ Wedding Anniversary, if married: _____

Sex: MALE / FEMALE Occupation: Desk / Driver / Heavy Lifting / Stand All Day / Low Stress / High Stress
Please explain: _____

Emergency Contact Name: _____Number: (____)_____

Please list all ALLERIES including LATEX, Medications, Food and other substances:

_____

Are you currently under a doctor's care? □ Yes □ No _____

Are you currently undergoing any medical treatments? □ Yes □ No

Please list all medications you are currently taking or have taken in the past 6 months, including prescriptions, herbal or over the counter medications.

_____

Do you suffer from claustrophobia? □ Yes □ No Do you have a pacemaker? □ Yes □ No
Stress levels may have an effect on your treatment, would you say your stress level is □ Average □ High

Female Only:
Are you pregnant: □ Yes □ No Please Check □ 1st □ 2nd □ 3rd Trimester
Are you breastfeeding? □ Yes □ No

Please Check the response that pertains to you condition ONLY Y or N

___ Blood Clots ___ Arthritis ___ Sciatica ___ Sinusitis
___Stress ___ Skin Rash ___ Upper Back Pain ___ Pregnant
___ Diabetes ___ Cancer ___ Lower Back Pain ___ Spinal Injuries
___ Allergies ___ Headaches ___ Contact Lenses ___ PMS
___Osteoporosis ___Diarrhea/Constipation ___ Cystic Fibrosis
___ Cardiac/Circulatory problems ___ Mental Illness
___ Rheumatoid/Osteoarthritis ___ Skin Sensitivity
___ Broken Bones ___ Fibromyalgia ___ Heavy Menstruation
___ Surgeries ___ TMJ (jaw pain)
___ Inflammatory Disease

Y N Do you have a thyroid condition? Y N Do you experience frequent headaches?
Y N Do you suffer from joint swelling? Y N Have you ever had surgery?
Year(s): _____ Y N Do you suffer from epilepsy or seizures?
Y N Do you have varicose veins? Y N Do you have any contagious diseases?
Y N Any injuries in the past two years? Y N Do you suffer from back pain?
Y N Do you have disk herniation? Y N Do you have numbness or stabbing pains?
Y N Do you use any topical hormones? Y N Are you sensitive to touch or pressure in any areas?
Y N Do you have high blood pressure and/or take medications to manage blood pressure? Y N Do you have cardiac or circulatory problems? Y N Do you have any allergies or sensitivities? (i.e. nuts, iodine, shellfish, flowers, scents)
Y N Any other medical conditions or medications you are taking?

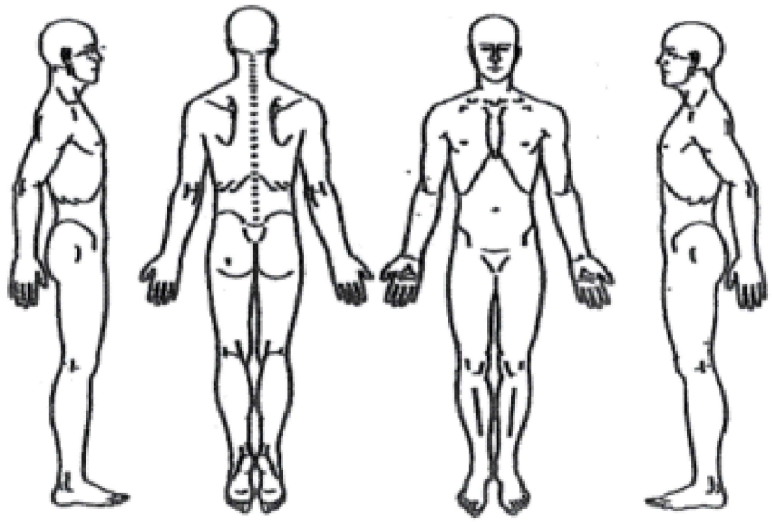
_____
Additional Medical Information Comments:

Do you have tingling or numbness in a specific area? Yes No Please mark the image below:

On a Scale of 1 – 2- 3 - 4 – 5 – 6 – 7 – 8 – 9 – 10 Indicate Your Pain!

KEY
Ɵ Mark Where General Pain Exists

KEY
§ Feeling Of Numbness
X Feeling of Stiffness
∞ Mark Extreme Pain
Φ Mark scars, Bruises or Wounds



Massage Therapy

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 may be contraindicated. A referral from your primary care provider may be required prior to providing service. Have you ever experienced a professional massage or bodywork session? Yes No How Recently? _____

If yes, what did you like about it?_____

What didn't you like about it? _____

If yes, do you like light, moderate, or deep pressure?_____

_____

Techniques including effleurage, petrissage, percussion, friction, and vibration (shaking/jostling) may be used during the session. All parts of the client's body may be massaged, but will not include the male and female genitals and female breasts. Any areas of the body that the client wishes to be avoided during the massage session, or that may need to be avoided due to a contraindication will be listed below. Any areas of the body that either the client or the therapist considers to need additional massage therapy may be indicated below.

Informed Consent

Customer satisfaction at Cynthelese Massage Spa is our number one goal, and therefore personal and professional boundaries are respected at all times.

It is understood by I _____, that the massage therapy given is for the purpose of reducing stress, relief from muscular tension or spasm, or to increase circulation and lymphatic flow. The massage therapist does not diagnose illness, medical treatments, nor performs spinal manipulations. It is understood that this treatment is not a substitute for medical examinations and/or treatments and that it is recommended that I seek a physician's advice should any ailment befall me. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on physical conditions that may occur in the future.

CONFIRMATIONS: As a courtesy, we ask that you give a 12 hour notice of appointment changes/alterations/cancellations. It takes time to prepare for massage & spa treatments, and therefore cancellations are required, refusal to do so may result in a charge of half the rate os your scheduled appointment.

Thank you for understanding that we make special provisions for our clients. We make every effort to schedule enough tie for each appointment, so as to be on-time for yours.

Draping will be maintained throughout the session. At any point a guest is uncomfortable, they may request to stop the service. It sets the stage for a professional massage and spa treatment.

Massage modalities requested (Circle one): Therapeutic massage / Prenatal Massage / Back Treatments / Hydrotherapy Treatments

The areas of the client's body to be massaged: Full Body / Neck & Shoulder / or Back

Areas to be avoided: _____ Reasons: _____

I have read and agree to the above terms. If uncomfortable for any reason, you may ask the therapist to cease the massage and they will end the massage session.

Client Signature: _____ Date: ____/___/_____

Licensed Massage Therapist Signature: _____ Date: ____/___/_____