Serenity Day Spa, LLC

Name: _____ Male/Female DOB:_____

Address: _____ (mailings may be sent here.) City:

_____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____

E-mail Address: (updates and coupons may be sent) _____

Occupation: _____ Spouse: _____

Who may we thank for referring you? _____

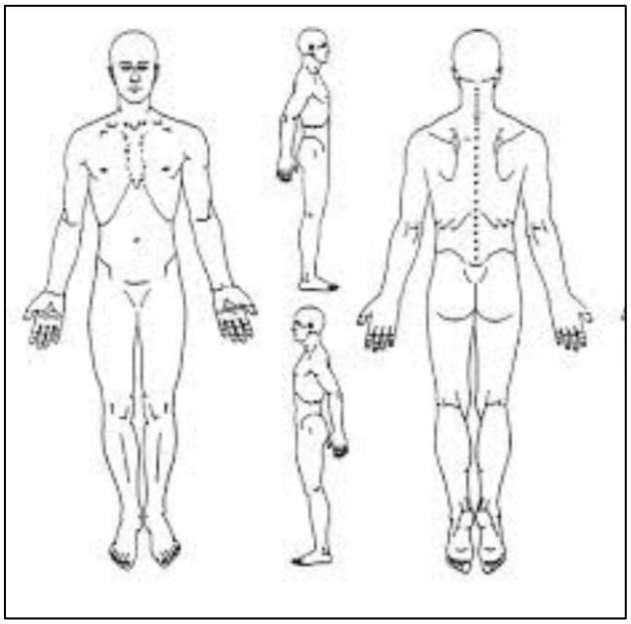
If having a "Therapeutic" massage, what is your **major complaint** or condition you want to improve on today?

What activities or products **aggravate** this condition?

improve this condition?

Height: Weight:

Are you under medical/therapeutic treatment? If yes, for what condition(s)?



Shade any area of concern.

List any **medications** (including aspirin, **herbs**, and vitamins) taken in the last 12 months & for what condition(s):

Informed Consent

I,_____, (**PRINT NAME**) am at least 18 years of age or older and understand that licensed massage therapy provided here at **Serenity Day Spa, LLC** is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified here:

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

_____ _____ Date _____

Date/ LMT **Client Signature**

Health History

Check the following conditions that apply to you, past and present. **Please *add your comments* to clarify the condition.**

MusculoSkeletal

❑ Headaches
❑ Joint stiffness/swelling
❑ Spasms/cramps
❑ Broken/fractured bones
❑ Strains/sprains
❑ Hip pain
❑ Shoulder, neck, arm, hand pain
❑ Leg, foot pain
❑ Chest, ribs, abdominal pain
❑ Back pain: upper, mid, lower
❑ Jaw pain/TMJ
❑ Tendonitis
❑ Bursitis
❑ Arthritis: OA or RA
❑ Osteoporosis
❑ Scoliosis
❑ Bone or joint disease
❑ Other:

Circulatory and Respiratory

❑ Dizziness
❑ Shortness of breath
❑ Fainting
❑ Cold feet or hands
❑ Cold sweats
❑ Swollen ankles
❑ Pressure sores
❑ Varicose veins
❑ Blood clots
❑ Stroke
❑ Heart condition
❑ Allergies
❑ Sinus problems
❑ Asthma
❑ High blood pressure
❑ Low blood pressure
❑ Lymphedema
❑ Other:

Nervous System

❑ Numbness/tingling
❑ Twitching of face
❑ Chronic pain
❑ Sleep disorders
❑ Ulcers
❑ Paralysis
❑ Herpes/shingles
❑ Cerebral Palsy
❑ Epilepsy
❑ Chronic Fatigue Syndrome
❑ Multiple Sclerosis
❑ Muscular Dystrophy
❑ Parkinson's disease
❑ Spinal cord injury
❑ Other:

Digestive

❑ Indigestion
❑ Constipation
❑ Intestinal gas/bloating
❑ Diarrhea
❑ Diverticulitis
❑ Irritable bowel syndrome
❑ Crohn's Disease
❑ Colitis
❑Other:

Skin

❑ Rashes
❑ Allergies
❑ Athlete's Foot
❑ Warts
❑ Moles of concern
❑ Acne
❑ Cosmetic surgery
❑ Other:

Recent:

❑ Injections
❑ Vaccinations
❑ Topical Medicines
❑ Patches
❑ Pumps (with location)
❑ Bruising
❑ Medication Side Effects

Reproductive System

❑ Pregnancy:
❑ Current ❑ Previous
❑ PMS
❑ Menopause: Pre, Current or Post?
❑ Pelvic Inflammatory Disease
❑ Endometriosis
❑ Hysterectomy
❑ Fertility concerns
❑ Prostate problems

Other

❑ Loss of appetite
❑ Forgetfulness
❑ Confusion
❑ Depression
❑ Difficulty concentrating

❑ Drug use _____
❑Alcohol use _____
Today?? _____
❑ Nicotine use _____
❑ Caffeine use _____

❑ Hearing impaired
❑ Visually impaired
❑ Burning upon urination
❑ Bladder infection
❑ Eating disorder
❑ Diabetes: Type I or Type II
❑ Fibromyalgia
❑ Post/Polio Syndrome
❑ Cancer
❑ **Infectious disease** (please list)
_____
❑ Other congenital or acquired disabilities (please list)

❑**SURGERIES: (list with year)**

Please list any additional comments regarding your health and wellbeing:

I have stated all conditions that I am aware of and this information is true and accurate. I will keep this Massage Therapist updated as to any changes in my status.

CLIENT'S SIGNATURE: _____ Date:_____

Serenity Day Spa,LLC Polices & Procedures

Conduct Polices: Pets are never allowed. We discourage **children (under 18)** accompanying parent in treatment rooms. Unsupervised children will not be allowed to stay in lobby. Children under 18 ***cannot*** fill out intake forms. Parents must stay with their children (under 16) at all times when they receive massage. Children 16-18 may receive massage with parents written consent when parent is not on premises on a case by case basis only when the therapist feels that it is appropriate. Written consent must be given directly to therapist by parent with valid photo ID.

Intake: A thorough intake will be done by your therapist prior to your massage. Home instructions, further appointments and referrals may be made if necessary. No product or service will ever be recommended outside of your best interest. We reserve the **right to refuse service** to anyone for any reason that indicates we cannot serve you appropriately or our safety is at risk. Clients with Shingles, poison ivy/oak, using testosterone cream and or recently vaccinated with smallpox/chickenpox cannot receive massage. Other illnesses and/or medications may also indicate caution or preclude massage. Clients are asked to not consume alcohol prior to massage.

Fee Polices: Payment expected at time of service and fees are listed in our most current brochure. We take cash, check or credit cards. We do not bill insurance. **Gift cards** are available for sale in our office and online. In the event of business cessation, your gift card may be transferred to another LMT outside of this business. All service prices are subject to change at anytime.

Service Guarantee: If for any reason you are **dissatisfied with your massage**, please give us the opportunity to make it right. We can reschedule you with another therapist or refund your money.

Discolorations: **MediCupping, Cupping, Magnetic Acupressure Cupping and Gua Sha** can cause localized pain. There is the possibility of discolorations that can occur from these tools as they release and clear stagnate cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by the lymphatic and circulatory systems. This is not bruising. Bruising occurs when pressure is applied to blood vessels, breaking them open. The discolorations will dissipate from a few hours to as long as several weeks in some cases and in relation to my after-care activities. The body's immune system can temporarily react to this release by producing flu-like effects such as nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release.You should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 12 hours. Exposure to such extremes can produce undesirable effects and you should avoid such situations.

Allergies/Sensitive Skin: If you have sensitivities, please let us know. We have sheets washed in hypo-allergenic soap, unscented apricot kernel oil and can remove aromatherapy from the room. **Please give 48 hours notice.** Clients with **Asthma** must have an inhaler with them during massage. Target Area Massage may cause bruising and discomfort for several days after massage. **Nitrile gloves** may be used by therapists, especially in TMJ intra-oral massage. Our Kinesio Tape® has an **acrylic (non-laytex) adhesive**. The dyes are made from organic plants. Alcohol, skin barrier wipes and spray adhesive may be used. We will happily let you see the list of ingredients prior to taping and give you a tape sample to try days ahead of time.

Appointment Polices: We insist on a **24 hours notice prior to canceling** or rescheduling an appointment. If your therapist cannot keep your appointment, all efforts will be made to book you with another therapist first before we cancel your appointment. **"No-shows"** will be called to reschedule. Clients with two "no-shows" & "last minute cancellation" will be asked to pay for the therapists time in advance of any further treatments with no refunds or credit being given for any subsequent no-shows or last minute cancellations. **If you are late**, time will ***not*** be added to your session as we cannot inconvenience other clients by starting their sessions late or a therapist that has other obligations outside of work.

Confidentiality: According to KY State law, your written consent must be given or a court order in place before we can release any of your information to anyone, unless there is an emergency medical necessity (heart attack, etc). All LMT's and administrative staff have full access to your information for the purposes of doing business for **Serenity Day Spa, LLC** and it will never be shared or used for solicitation outside of this business. We are a "non-covered" HIPAA entity. You file is stored for 5 years in a locked area and password protected information is stored on a secure computer.

SEXUAL CONDUCT: sexually suggestive behavior and/or conversation by clients (towards therapist or with their own selves) is never allowed on any level and will be reported immediately to the **POLICE for criminal & public prosecution** (SOLICITATION). Those attempting this ***pathetic and depraved behavior*** will be permanently banned from the premises in order to maintain a safe work environment for our employees. NO MONGERING!

I _____**(print)** have read the above polices, understand them and agree to follow them. I have also been given an informational brochure listing current Massage Etiquette, Instructions for Before/During/After My Massage, Benefits of Massage, Contraindications of Massage and a copy of these Policies and Procedures (rev. 12/19') to take home. I have had an opportunity to ask questions regarding anything that I didn't understand and have had questions answered to my satisfaction. I understand that my massage therapist cannot diagnose, prescribe, do adjustments or perform any surgically related procedures.

Client Signature _____ date _____LMT Initials _____