Serenity Massage and Day Spa
Confidential Health Information Form

Name	E-mail
Address	Occupation

Home Phone	Cell/Work Phone	Emergency Contact Name/Phone	Date of Birth
( ) -	( ) -	( ) -	/ /

How did you hear about us?
☐Website ☐ Yellow Pages ☐Newspaper ☐ Referral (by_____) ☐Other_____

Medical History (please check all that apply and explain below)

___Allergies/Sensitivities	___Easy Bruising	___Physical or Emotional Trauma
___AIDS	___Epilepsy	___Plantar Fasciitis
___Arthritis: Osteo or Rheumatoid	___Fibromyalgia	___Pregnant/Lactating: Week #_____
___Asthma/Lung Conditions	___Frozen Shoulder	___Sciatica
___Athlete's Foot	___Hearing Aids	___Scoliosis
___Bladder Problems	___Hemophilia	___Skin Conditions
___Bursitis	___High or Low Blood Pressure	___Sleeping Disorders
___Cancer	___Heart Condition/Pace Maker	___Surgery
___Carpal Tunnel Syndrome	___Headaches/Migraines	___Thoracic Outlet Syndrome
___Chronic Illness	___Hypo/Hyper Thyroid	___TMJ Dysfunction
___Contact Lenses	___Immune Disorder	___Varicose Veins
___Dentures	___Kidney Disease	___Blood Clots/Deep Vein Thrombosis
___Depression	___Motor Vehicle Accident	___Whiplash
___Diabetes	___Open Wound/Lesion or Infection	___Other

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Have you ever had a professional massage before? Yes/No If yes, how often do you receive massage?_____

Do you exercise regularly? Yes/No If yes, how often?_____

Do you have any difficulty lying on your front, back or side? Yes/No If yes, please explain _____

_____

Are you taking any medication, herbal remedies or vitamins?_____

_____

_____

Do you have any other medical conditions that your massage practitioner should be aware of before you receive your massage?

_____

Is there a particular area of the body where you are experiencing tension, stiffness pain or other discomfort?_____

_____

Do you have any particular goals in mind for this massage? _____

_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so the pressure may be adjusted to my level of comfort. I further understand that massage practitioners do not diagnose illness, disease or other medical, physical or emotional disorders or prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that I am responsible for consulting a qualified physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health. I also affirm that I am at least 18 years of age or have parent consent to receive my massage today (if under 18, parent signature must be present). Since spa services have been reserved especially for me, I will notify my practitioner 24 hours in advance to change/cancel future appointments.

Signature of client (or guardian)_____**Date**_____