SERENITY
massage & wellness spa

Name _____ Birth Date _____

Address _____ City _____ State, Zip Code _____

Email address _____ Do you want to receive our specials? Y N

Referred by _____ Cell Phone _____

Occupation _____ Home Phone _____

Have you had a professional massage before? Y N If yes, how often? _____ Last massage? _____

Are you under a doctor's care? Y N If yes, why? _____

Are you allergic to any oils, creams, or fragrances? Y N If yes, what? _____

Do you exercise regularly and/or participate in any sports? Y N

Do you perform any repetitive movement in your work, sports, or hobbies? Y N

Do you sit for long hours as a workstation, computer, or driving? Y N

Do you have problems with any of the following? (Check all that apply – Circle the areas needing the most attention)

( ) Headaches	( ) Tension	( ) Stomach	( ) Circulation
( ) Joints	( ) Low Back	( ) Digestion	( ) Respiration
( ) Sinus	( ) Shoulder	( ) Spinal	( ) Kidney
( ) Fatigue	( ) Neck	( ) Insomnia	( ) Misc.

Have you been diagnosed with any of the following?

( ) Heart Problems	( ) Chronic Fatigue	( ) Diabetes	( ) Arrhythmia
( ) High Blood Pressure	( ) Varicose Veins	( ) Aneurysm	( ) Fibromyalgia
( ) Low Blood Pressure	( ) Arthritis	( ) Pregnant- Weeks?	

Mark any areas you DO NOT want worked on: ☐ **Stomach** ☐ **Feet** ☐ **Face** ☐ **Glutes (buttocks)** ☐ **Hair**

List: Medications: _____

Operations: _____

Other Medical Conditions: _____

Client Agreement:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. Therefore, the massage therapist prescribes neither medical treatment, nor pharmaceutical, nor performs any spinal manipulations. It has been made clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my health and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that massage therapy involves hands on application pressure to relieve muscle tension. I have no condition that would contraindicate this, and the practitioner has my permission to apply massage therapy techniques.

_____ _____

Signature of Client Date