

SUE KOLVE'S

SALON & DAY SPA

This form must be completed and signed before receiving massage.

Name _____ Today's Date ___/___/___

Referred by _____ Email Address _____

Date of Birth ___/___/___ Age _____ M / F Occupation _____

Phone #: Home _____ Work _____ Cell _____

Address _____ City _____ State _____ Zip _____

Emergency Contact: Name & Phone _____

Primary Physician _____

What is your hope or goal in receiving massage therapy today?

Have you had professional massage therapy before? Yes/ No

Are you pregnant? Yes/ No Number of weeks _____

Do you do any exercise or sports? Yes/No If yes, what kind? How often? _____.

Do you take any medications, vitamins, or herbs? Please list. _____

Do you have any form of infectious, contagious, or skin diseases? Yes/ No If yes, describe. _____

Do you have any of the following:(please check any that apply)

High or Low Blood Pressure Varicose Veins Blood Clots/Phlebitis

Menstrual Pain PMS Menopause HIV/AIDS Diabetes Asthma

Epilepsy/Seizures Multiple Sclerosis Cancer Numbness/Tingling Heart

Problems Circulatory Problems Stress Headaches/Migraines

Osteoporosis Restless Leg Arthritis Depression

Joint Pain/Limitation/Swelling Muscular Cramps Allergies

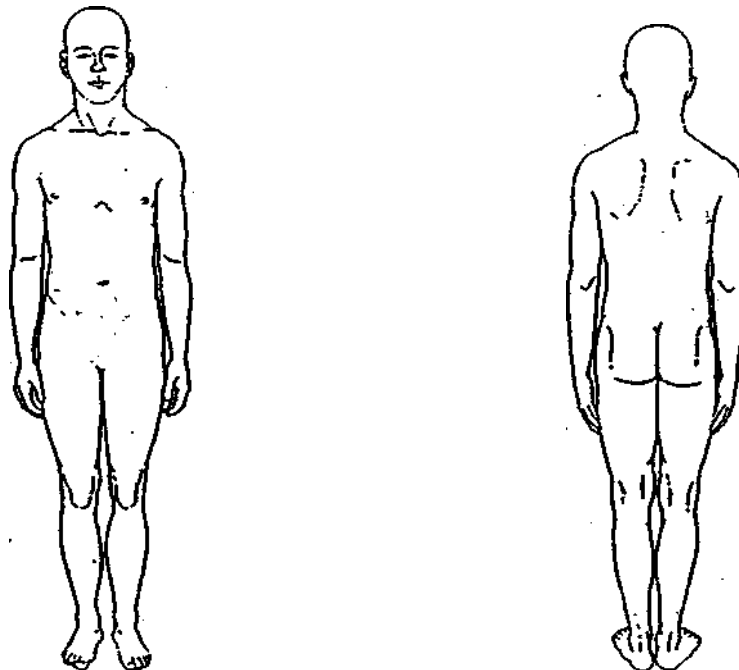
Have you had any major illnesses, injuries, accidents, or surgeries? If so, when? _____

Are you wearing? Contacts? Dentures? Hearing Aids?

I understand that the massage therapy and bodywork I receive is provided for the purposes of relaxation, stress reduction, relief of muscular tension and spasm, and improvement of circulation and energy flow. I agree to actively participate, as much as possible, in my own healing and health maintenance. 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 massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I understand that any information provided by the massage therapist is for educational purposes only, and is not diagnostically prescriptive in nature.

Please indicate on diagrams below areas of pain or discomfort.

Indicate any additional area you would like attention. _____



Since massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that any illicit or sexually suggested remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. I have received the policy statement, and have read and agree to the policies therein.

Client Signature _____ Date _____