

Body RESTORATION® **Massage Profile**

Name _____ Address _____

City _____ State _____ Zip _____ Date of Birth _____

Email: _____ Phone(Day) _____ (Night) _____

Profession _____ How did you hear about us? _____

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 service being provided.

If you answer “yes” to any of the following questions, please explain as clearly as possible.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you frequently suffer from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have osteoporosis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any allergies or sensitivities (i.e. nuts, iodine, shellfish, flowers, scents)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have a thyroid condition? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you experience frequent headaches? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bruise easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any broken bones in the past 2 years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you wearing contacts or dentures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any injuries in the past 2 years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have cardiac or circulatory problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from back pain or disk herniation? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have high blood pressure and/or take medication to manage blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have numbness or stabbing pains? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from epilepsy or seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you sensitive to touch or pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you suffer from joint swelling? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had surgery? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have varicose veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other medical conditions, or are you taking any medications? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any contagious diseases? | | |

Comments _____

Have you ever experienced a professional massage or bodywork session? Yes No How recently? _____

What are your goals for today's treatment? _____

What kind of pressure do you prefer? light medium firm

I understand that massage therapy and spa treatments are given for the purpose of stress reduction, skin purification, reduction of muscle tension and pain, and to increase circulation and energy flow. Massage and body therapists and estheticians do not diagnose illness, disease, or any physical or mental condition, and nothing said during the course of treatment should be construed as diagnosis or treatment. I have stated all known conditions and take full responsibility to inform the spa therapists of any new information regarding my physical condition. I understand that certain conditions, including intoxication are contraindicated for skin and body services, and the spa reserves the right to recommend that I reschedule a treatment at their discretion.

Signature: _____ **Date:** _____