Spa Bliss

Information Form

Name:____

Home #: _________________________ Mobile#: ____________________________

Address: ____

City: ________________________ State: ______________ Zip Code: ___________

Email: ______________________

Date Of Birth: __________________ Age: ______________ M ______ F_____

Occupation: ___________________ Referred By:___________________________

How did you hear about us?____

Have you ever received Massage Therapy? Yes _____ No _____

Type of massage experienced: _____ Deep Tissue _____ Swedish

Other ______________________

When was your last massage treatment ? ____________________________________

What are your treatment goals? ____ Relaxation ______ Therapeutic ______ Both

Areas to avoid ____

Are you taking any medications? _________

If yes, please describe ____

Have you consumed alcohol in the past 24 hours? _____ Yes ____ No

Are you currently pregnant or nursing? ____________ Yes ____ No, If yes _______Weeks

Do you have a history of the following?

_____ Allergies to oils or perfumes
_____ Accidents
_____ Abdominal Pain
_____ Arthritis
_____ Athlete's Foot
_____ Broken Bones
_____ Bruise Easily
_____ Breast Argumentation
_____ Bursitis
_____ Contagious Disease
_____ Cancer
_____ Cardiac/ Circulatory Problems

______ Colitis
______ Diabetes
______ Disk Problems
______ Decreased Range of Motion
______ Epilepsy/ Seizures
______ Fibromyalgia
______ Gout
______ Headaches/ Migraines
______ Heart Attack
______ High Blood Pressure
______ HIV
______ Low Back Pain
______ Mid Back Pain

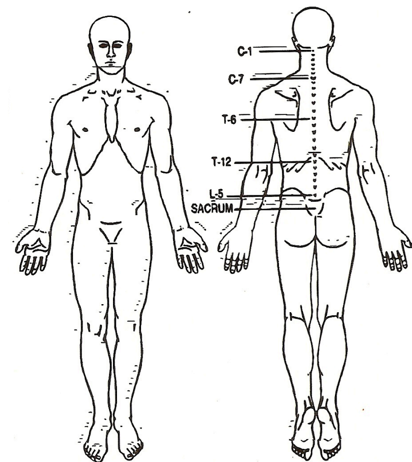
______ Pacemaker
______ Numbness/ Stabbing Pain
______ Skin Disorder
______ Surgery
______ Stroke
______ Undergoing Recent Laser treatment
______ Varicose Veins
______ Wear Contact or other Prosthesis

Do you have any of the following today:

___ Cold/ Flu
___ Headache
___ Inflammation
___ Sunburn

___ Irritated Skin Rash
___ Open Cuts, Bruises, Burns
___ Poison Ivy
___ Severe Pain

Please indicate with an {X} the place you are experiencing discomfort.



Please read the following and sign below:
* I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
* I am responsible for paying for any appointment cancellation of less than 24 hours.

Date: ___________________________

Signature____