

INNERLIGHT HEALTH SPA

(845) 229-9998 - www.InnerLightHealthSpa.com

Massage Client History Form

Name _____ Date _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Would you like to receive the monthly InnerLight Bulb e-Newsletter? Yes No

How did you hear about us? _____

Date of Birth ____/____/____ Height _____ Weight _____

Occupation _____

Activities or repetitive motions _____

Primary reason for appointment _____

Have you ever had a professional massage? Yes No

Please check any conditions that you have, or have had in the past:

- | | | |
|--------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> headaches | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> allergies | <input type="checkbox"/> vision problems, contacts | <input type="checkbox"/> abdominal, digestive problems |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> blood clots | <input type="checkbox"/> hernia |
| <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> arthritis, tendonitis | <input type="checkbox"/> tension, stress |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> jaw pain, TMJ | <input type="checkbox"/> constipation, diarrhea |
| <input type="checkbox"/> circulatory problems | <input type="checkbox"/> cancer, tumor | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> muscle or bone injuries | <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> asthma, lung problems | <input type="checkbox"/> hearing problems | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> unlisted condition |

Comments regarding checked conditions above:

Have you had significant surgeries or illnesses in the past six month's? Yes No

Have you been cleared by a Doctor to receive massage? Yes No

Please list all medications you are currently taking: _____

Are you pregnant or trying to conceive? Yes No

Do you prefer light____ moderate____ or deep____ pressure?

Do you want work done to your glutes _____ abdomen _____

Your comfort is our concern. Please let us know if you are hot, cold, uncomfortable or just right. Please note our lateness and cancellation policy. If you are late for your appointment, we do expect full payment and we are only able to accommodate ten minutes beyond your scheduled end time. If you do not show up or cancel without 24 hours advanced notice, we do expect full payment. We appreciate your business and most of all your respect. Thank you.

I attest that the above information is true to the best of my knowledge and I release InnerLight Health Spa, with associated therapists, of liability as a result of anything other than malpractice.

Client Signature _____ Date ____/____/____