Sundays
ULTIMATE DAY SPA

MASSAGE CONSULTATION FORM

Today's Date: _____

Name _____ Birthday _____

Address _____

City _____ State _____ Zip code _____

Home Phone # _____ Work Phone # _____ Cell # _____

Occupation _____Email Address: _____

Marital Status _____ Male _____ Female _____ Emergency Contact _____ # _____

MASSAGE/MEDICAL TREATMENT HISTORY

Have you ever received a professional massage? Yes____ No____
Are you currently seeing a medical practitioner? Yes____ No____

Reason for Last Doctor's Visit _____ Date _____

If yes, please explain: _____

List current medications including aspirin, ibuprofen, etc.

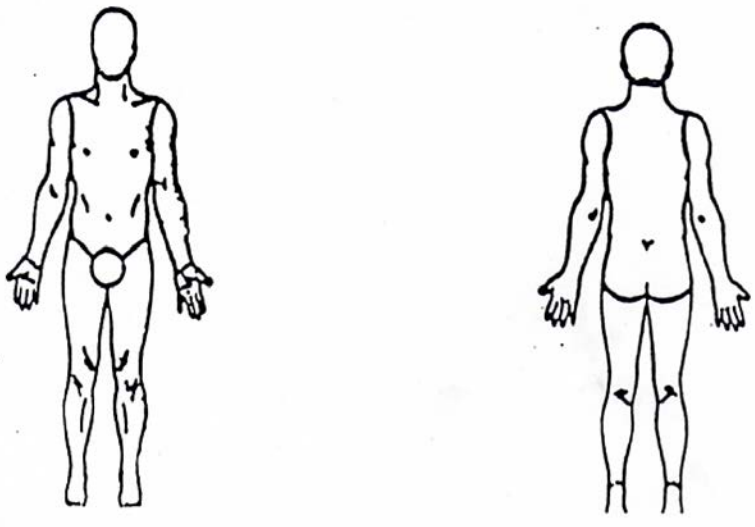
_____

Accidents or surgery in the past six (6) years: _____

Comments: _____

_____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



HEALTH HISTORY

Muscular – Skeletal-please indicate left or right side

__ bone or joint disease _____
__tendonitis/bursitis_____
__disk disease_____
__ broken/fractured _____
__ arthritis _____
__ sprains/strains _____
__ low back, hip(s), arm(s) pain _____
__ headaches/head injuries _____
__ spasms/cramps _____
__ jaw pain/TMJ _____
__ Lupus _____
__ Fibromyalgia _____
__ Other _____

Skin

__ allergies _____
__ rashes _____
__ athletes foot _____
__ warts _____
__ other _____

Nervous System

__ Herpes/Shingles _____
__ numbness/tingling _____
__ chronic pain _____
__ sleep disorders _____
__ other _____

Infectious Disease(s)

Please list _____

Circulatory/Respiratory

__ heart condition _____
__ varicose veins _____
__ history of blood clots _____
__ high blood pressure _____
__ low blood pressure _____
__ lymphedema _____
__ breathing difficulty _____
__ asthma _____
__ sinus problems _____
__ allergies _____
__ smoker _____
__ other _____

Digestive

__ constipation _____
__ gas/bloating _____
__ diverticulitis _____
__ irritable bowel syndrome _____
__ other _____

Reproductive

__ Are you pregnant? _____ Stage _____
__ PMS _____
__# of children_____

Other

__ cancer/tumors _____
__ diabetes _____
__ depression _____
__ coffee drinker _____
__ Left or right handed (circle)

PERSONAL RELEASE STATEMENT

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorders, nor do they prescribe medical treatment, pharmaceutical or perform spinal thrust manipulations. I acknowledge that massage therapy is not a substitute for medical examination or treatment and that it is recommended that I see a primary healthcare provider for that service.

I have stated all medical conditions that I am aware of and I will update the massage practitioner of any changes in my health status.

_____ _____

Customers Signature Today's Date