BELLE ROSS SPA & SALON
CONFIDENTIAL CLIENT INFORMATION FORM- PLEASE PRINT

Name:____D.O.B:____________________________Email:___________

Address:____City:________________________ST:_________Zip:_________

Phone: (Home)(______)______________________________(Work)(______)___________________________(Cell)(______)_________________

Employer:____Occupation:_______________________________

Emergency Contact Person:____Phone:__________________________

Referred by:____

Previous Experience with Massage:____

Date of Last Massage:____

Primary Reason for Appointment/Areas of Pain or Tension:____

____

Because massage has both physical and mental/emotional affects it is important to keep the massage therapist aware of your health status. Are you currently seeing a health care provider? NO________ YES________

Permission to contact health care provider or massage therapist/physical therapist/ occupational therapist/ chiropractor

Physician:____Phone:_____________________________Initial for Permission:_________

Therapist:____Phone:_____________________________Initial for Permission:_________

Please mark (X) to all conditions that apply now. Put a P for past conditions. Put F for family history of illness.

___ Headaches, Migraines
___Vision Problems, Contact Lenses
___ Hearing Problems, Deafness
___ Injuries to face or head
___Sinus Problems
___ Dental Bridges, Braces
___ Jaw Pain, TMJ Problems
___ Asthma or Lung Conditions
___ Hernia (Hiatal/Inguinal)
___ Constipation/Diarrhea
___ Congestive Heart Failure

___ Chronic Pain
___ Muscle or Joint Pain
___ Muscle, Bone Injuries
___ Numbness or Tingling
___ Sprains, Strains
___ Arthritis, Tendonitis
___ Cancer, Tumors
___ Spinal Column Disorders
___ Diabetes
___ Pregnancy (Trimester:_____)
___ Skin Disorders

___ Fatigue
___ Tension, Stress
___ Depression
___ Sleep Difficulties
___ Allergies, Sensitivity
___ Rash, Athletes Foot
___ Infectious Disease
___ Blood Clots
___ Varicose Veins
___High/Low Blood Pressure
___ Other (_____________)

Current medications, including asprin, ibuprofen, herbs, vitamins, etc:____

____

Surgeries:____

Accidents:____

Please list all forms and frequency of stress-reductions activities, hobbies, exercise, or sports participation:

____

Please read the following statements and sign below

- I understand this massage is NOT a replacement for medical care.
- I have disclosed any conditions that massage therapy may aggravate.
- I understand that any illicit or sexually suggestive remarks or advances made by me or you will result in immediate termination of the session, and I or you will be liable for payment for the full scheduled session.
- My session may be abbreviated if I did not arrive at scheduled time

Client Signature:____Date:__________

Therapist Signature:____Date:__________