HAND & STONE®
MASSAGE AND FACIAL SPA

MASSAGE THERAPY CLIENT PROFILE

Last Updated: _____

Please complete this form as completely as possible – accurate, up-to-date health information ensures you receive safe and effective care. If you have a medical condition, please consult your physician to ensure massage therapy will be helpful to you. All health information gathered for this treatment is confidential except as required by law, to facilitate assessment or treatment, or to provide information to health plan insurers. The clinical notes for your appointment entered by your Therapist will be available to our other in order to ensure you are provided with the appropriate treatment at each appointment. For more information, please inquire about our privacy policy.

Name: (first, m.i., last) _____

Address: _____

City: _____ Province: _____ Postal code: _____

Telephone: home ( ) _____ cell ( ) _____

E-Mail: _____

Birth date: _____(Month)/_____(Day)/_____(Year) Occupation: _____

How were you referred to us? ❑ STOREFRONT ❑ WORD OF MOUTH ❑ DIRECT MAIL

❑ WEB SITE ❑ OTHER _____

Emergency contact and phone: _____

PHYSICIAN: _____ PHONE: ( ) _____
(Name & Address)

Please outline any medical conditions, surgeries, injuries or car accidents (please include dates):

_____

_____

_____

_____

Please list your medications and the conditions they are treating, other types of therapies you're receiving, and any allergies (and anaphylaxis):

_____

_____

_____

_____

What is the reason for your visit today?

❑ Relaxation ❑ Muscular Tension ❑ Injury_____

❑ Headache ❑ Health/Wellness ❑ Other _____

Have you ever had a massage? ❑ YES ❑ NO General Health ❑ Good ❑ Fair ❑ Poor

How frequent? ❑ Weekly ❑ Bi-Monthly ❑ Monthly ❑ Bi-Yearly ❑ Yearly

Have you tried a hot stone massage? ❑ YES ☑ NO

What kind of pressure do you prefer? ❑ Light ❑ Medium ❑ Firm ❑ Not Sure

(over please)

Please mark 'C' for current, 'P' for past or 'F' for family history beside each condition that applies.

Joint/Soft Tissue Discomfort

- ❑ Arms ❑ Right ❑ Left
- ❑ Upper Back
- ❑ Mid Back
- ❑ Lower Back
- ❑ Degenerative Discs
- ❑ Pins, Wires, Artificial Joints, Special Equipment
- ❑ Hands ❑ Right ❑ Left
- ❑ Hips ❑ Right ❑ Left
- ❑ Jaw
- ❑ Knees ❑ Right ❑ Left
- ❑ Legs /Feet ❑ Right ❑ Left
- ❑ Shoulders ❑ Right ❑ Left
- ❑ Neck
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Other _____

Respiratory

- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Hay Fever
- ❑ Difficulty Breathing/Short of Breath
- ❑ Smoking
- ❑ Emphysema
- ❑ Pneumonia

Digestive

- ❑ Poor Appetite
- ❑ Belching Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other _____

Symptoms / Conditions

- ❑ Fainting or Dizziness
- ❑ Fatigue
- ❑ Loss of Sleep
- ❑ Epilepsy or Neurological
- ❑ Nervousness
- ❑ Sudden Weight Loss/Gain
- ❑ Numbness and Tingling
- ❑ Paralysis
- ❑ Headaches / Migraines
- ❑ Arthritis
- ❑ Poor Appetite
- ❑ Mental Illness (type) _____ _____

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ History of Stroke/CVA
- ❑ Chronic Congestive Heart Failure
- ❑ Pacemaker/Special Equip.
- ❑ History of Myocardial Infarction
- ❑ Heart Disease
- ❑ Varicose Veins/Phlebitis
- ❑ Swelling of the Ankles
- ❑ Poor Circulation
- ❑ Haemophilia
- ❑ Diabetes

Infectious Conditions or Immune Diseases

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Herpes/Skin Infection
- ❑ Cold or Flu
- ❑ Athlete's Foot or Warts
- ❑ Cancer (type)_____
- ❑ Other _____

Skin Conditions

- ❑ Rashes
- ❑ Itching
- ❑ Bruise Easily
- ❑ Dryness
- ❑ Boils
- ❑ Other _____

Reproductive

- ❑ Pregnancy (due date) _____
- ❑ Painful Menstruation
- ❑ Heavy Flow
- ❑ Irregular Cycle
- ❑ Swollen Breasts
- ❑ Menopausal
- ❑ Pre-menopausal
- ❑ Gynecological Conditions (type) _____ _____

Eye, Ear, Nose, Throat

- ❑ Sinus Infection
- ❑ Glasses or Contact Lenses
- ❑ Vision or Hearing Loss/Loss of Sensation
- ❑ Hearing Aid
- ❑ Other _____

Consent: I understand that the massage therapy I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy is not a substitute for medical examination, diagnosis or treatment and that I should see a physician or qualified medical specialist for any physical or medical ailment of which I am aware. I understand massage therapy should not be performed under ce rtain medical conditions, and I affirm that I have stated all my known medical conditions and have answered all questions accurately.

I understand that I may disrobe to my comfort level. I acknowledge that it is my choice of a female or male massage therapist and that I may stop the treatment at any time if I am in any way uncomfortable.

I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at th eir sole discretion. I have read and fully understand this form in its entirety. If at any time there are changes in the inf ormation given, or in my condition, I will notify my therapist, and update this form before receiving additional massages.

My signature below affirms that I have read and agreed to the foregoing.

SIGNATURE: _____ **DATE:** _____

Consent to treatment of minor: By my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer massage or bodywork techniques to my minor child or dependent as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____